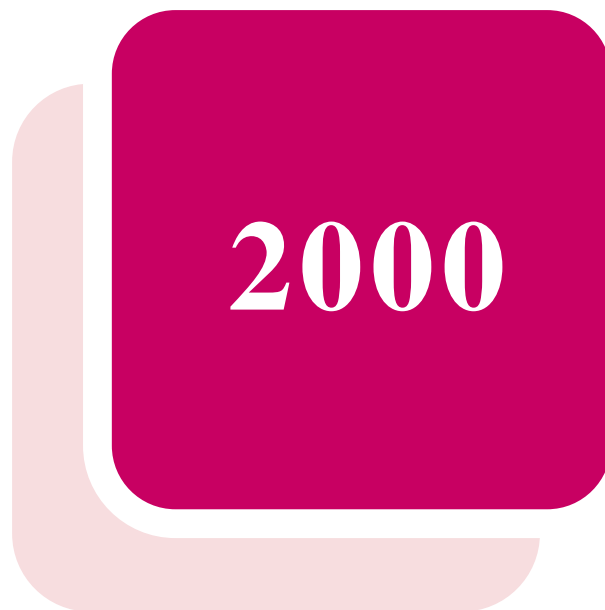


**Texas Department of Health  
Bureau of HIV and STD Prevention**

**HIV/STD  
ANNUAL REPORT**



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**Chair, Texas Board of Health**

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# TABLE OF CONTENTS

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List of Figures .....	ii
List of Tables .....	ii
Acknowledgements .....	ii
I. Executive Summary .....	1
II. Bureau of HIV and STD Prevention .....	2
III. Funding – Fiscal Year 2000 .....	4
IV. Epidemiologic Assessment .....	5
V. HIV Prevention and Services .....	19
VI. STD Prevention and Services .....	30
VII. Training and Public Education .....	36
VIII. HIV/STD Clinical Resources .....	40
IX. Appendix .....	48

## List of Figures

1. Organizational Chart.....	3
2. HIV Prevention and Services Contracts Awarded .....	4
3. AIDS Cases by Year of Report .....	5
4. HIV/AIDS Cases by Race/Ethnicity, 1999 .....	8
5. Adult-Adolescent AIDS Cases by Mode of Exposure & Sex .....	10
6. Adult-Adolescent HIV Cases by Mode of Exposure & Sex.....	10
7. Primary and Secondary Syphilis Rates by Race/Ethnicity .....	12
8. Syphilis Rates, Texas 1972-1999.....	14
9. Chlamydia Rates for Females, TX 1991-1999 .....	15
10. Gonorrhea Rates for Females, TX 1991-1999 .....	16
11. Chlamydia and Gonorrhea by Age Group .....	18
12. Percentage of HIV Tests and Positive Tests by Sex and Ethnicity .....	24
13. Percentage of HIV Tests and Positive Tests by Sex and Mode of Exposure.....	25
14. The Disease Intervention Process .....	32
15. Texas HIV Medication Program .....	41

## List of Tables

1. TX AIDS Deaths, Comparison by Race and Sex .....	6
2. AIDS Cases Reported in 1999 by Race and Sex .....	7
3. HIV Cases Reported by Race/Ethnicity and Sex 1999 .....	8
4. HIV Medication Allocations by Region.....	45

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# I. EXECUTIVE SUMMARY

From the beginning of the Human Immunodeficiency Virus (HIV) epidemic in the early 1980s to the end of 1999, over 54,881 acquired immunodeficiency syndrome (AIDS) cases have been reported in Texas. A total of 108,903 sexually transmitted disease (STD) cases were reported in Texas in 1999. While reported cases of syphilis declined, chlamydia, gonorrhea and pelvic inflammatory disease (PID) increased. Young people aged 15 to 24 years accounted for over 66 percent of all reported STDs, with adolescents aged 15 to 19 accounting for over 34 percent of these cases.

The total operating budget for HIV and STD programs, Bureau of HIV and STD Prevention, Texas Department of Health (TDH), for fiscal year (FY) 2000 was \$101,211,227. The Bureau distributed almost \$41 million to regional and local health departments and community-based organizations throughout the State in 2000. In addition, nearly \$45 million was spent to provide HIV and STD medications to Texas residents during FY 2000.

HIV prevention efforts focused on the high risk target populations identified through community planning activities. A total of 123,640 initial prevention counseling sessions were reported in 1999; 96 percent of initial counseling sessions included an HIV test, and this testing yielded a positivity rate of 1.0 positives per 100 tests. Over 10,000 HIV positive clients received publicly funded medical support services in FY 2000. Prevention activities provided by STD programs resulted in an estimated \$48,391,000 savings in medical costs related to STDs and \$21,336,000 savings related specifically to HIV. Disease Intervention Specialists (DIS) interviewed and managed 1,487 syphilis cases in Texas in 1999. A total of 799 contacts to syphilis cases were referred by DIS and provided preventative therapy, resulting in the prevention of 404 additional cases of syphilis.

HIV counselors were trained at many locations across Texas. Many counselors received customized training specific to the individual needs of their programs. The Texas HIV/STD InfoLine, which provides a telephone link between the people of Texas and the TDH, received over 2,772 calls during FY 2000.

The Texas HIV Medication Program distributed over \$42.9 million dollars of antiretrovirals and other HIV prophylactic medications in FY 2000, a 19.6 percent increase over 1999 levels. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. The Medication Reimbursement Initiative paid deductibles and co-insurance payments in the amount of \$37,867. The Texas HIV Medication Program also distributed \$1,015,500 in STD medications and supplies to 52 sites statewide in 2000.

\*Note. The Annual Report for 2000 is based on the previous fiscal year, September 1999 - August 2000. Due to time constraints in collecting and reporting research and epidemiological data, those sections of the report are based on the previous calendar year, January 1999 - December 1999.

## II. BUREAU OF HIV & STD PREVENTION

The Texas Department of Health (TDH), Bureau of HIV and STD Prevention consists of three Divisions: the HIV/STD Health Resources Division; the Epidemiology Division; and the Clinical Resources Division (**Figure 1**). The HIV/STD Health Resources Division is responsible for policy and planning, field operations, monitoring, training and technical assistance, and grants and contract development. The Epidemiology Division includes surveillance, epidemiologic assessment, research and evaluation, data management and other technical functions. The Clinical Resources Division supports all medication programs across the department including the Texas HIV Medication Program. Additionally, the Clinical Resources Division provides expertise, technical assistance, and policy direction on all clinical issues.

### Mission Statement

*Our mission is to prevent, treat, and/or control the spread of HIV, STD, and other communicable diseases to protect the health of the citizens of Texas. In keeping with this mission, we procure, allocate, and manage fiscal and human resources so that we may:*

*Provide HIV/STD education and information,  
Collect, interpret, and distribute data relating to HIV and STD,  
Provide guidance to those who oversee, plan for, or provide HIV and STD services, and  
Provide medication and supplies to prevent, manage, and treat communicable diseases.*

*In pursuit of this mission, we will make every effort to assure that the citizens of Texas receive quality services.*

The Bureau of HIV and STD Prevention is dedicated to preventing the spread of HIV and other STDs and minimizing complications and costs. This is achieved primarily through education, prevention counseling, screening and testing, partner elicitation and notification, and the provision of medical and social services. The TDH provides some of these services directly, but most often through contracts with local agencies to provide community-based services when appropriate. This report documents many of the activities and accomplishments of the Bureau in 2000 and provides an epidemiologic assessment of HIV, AIDS, and STDs in Texas.

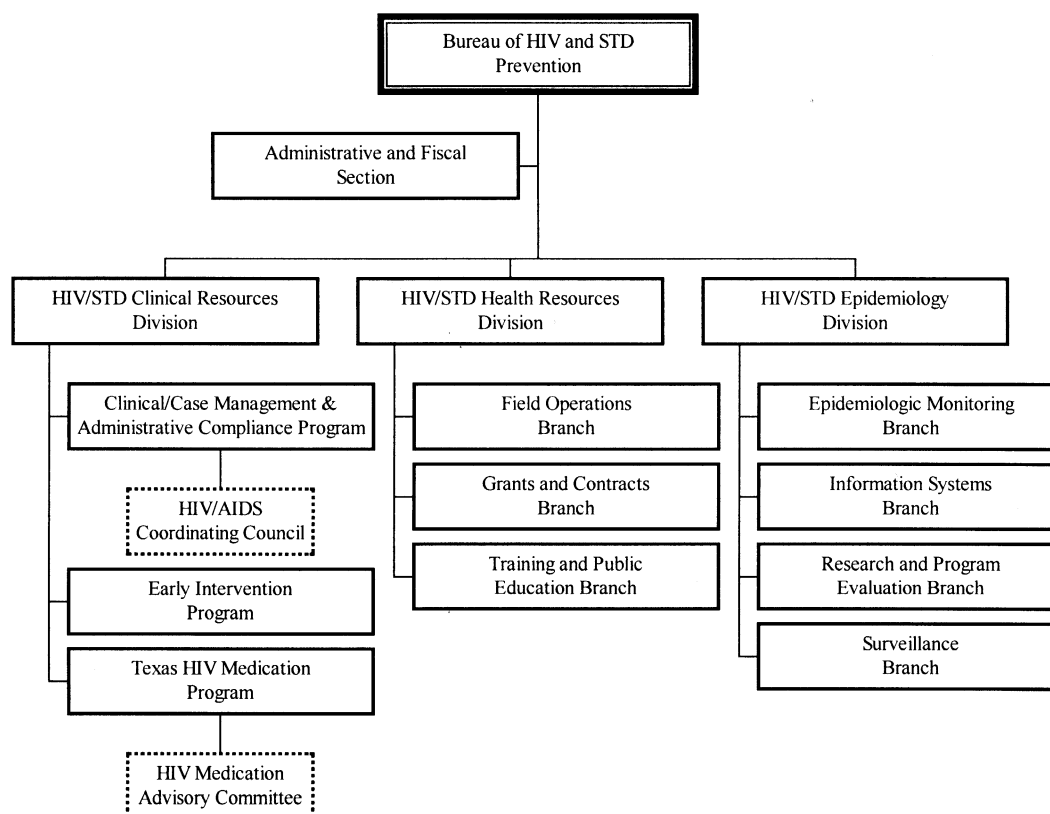
### Bureau of HIV and STD Prevention Strategic Plan

The Bureau's first strategic plan was completed in March of 1998, and the strategies in the plan were operationalized through the development of a one-year Strategic Operational Plan for September 1, 1999, through August 31, 2000. Implementation of the Strategic Operational Plan was accomplished through tasks related to issues and strategies identified in the Strategic Plan and

assigned to lead and collaborating staff at the branch level. The Strategic Operational Plan also served as a basis for the development of employee performance standards. Planning staff monitored status toward task completion through quarterly reports and revision of tasks and staff assignments to accurately reflect the actual scope of work. Planning staff will again work closely with managers and staff to develop a second-year Strategic Operational Plan to be implemented September 1, 2000 – August 31, 2001.

The Bureau's Strategic Plan Steering Committee was reconvened in February, 2000, to discuss an optimal mechanism to monitor progress on the Strategic Plan. The discussion resulted in the proposal to utilize prioritized initiatives as a basis for a revised Strategic Plan to monitor progress and more clearly define the Bureau's scope of work. An initiative-based format is intended to more strongly support staff collaboration and promotion of the Bureau's mission and to provide a natural framework for progress reports. The prioritized initiatives in the revised Strategic Plan will then serve as a basis for assigning milestones, timelines and responsible staff for the Strategic Operational Plan for September 1, 2001 – August 31, 2002.

**Figure 1. Organizational Chart**



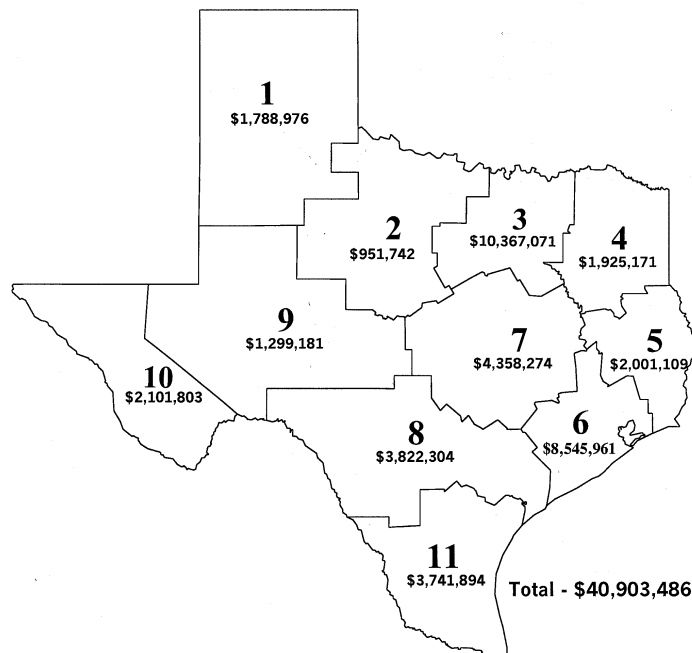
### III. FUNDING – FISCAL YEAR 2000



The total operating budget for HIV and STD programs for FY 2000 was \$101,211,227. Almost three-quarters of the budget, \$73,746,783, was provided by federal HIV and STD grants, and the remainder, \$27,464,444 by State funds. The HIV and STD funds were allocated as follows: \$21,699,784 (21%) for prevention; \$29,086,741 (29%) for services; \$44,974,586 (45%) for medication; and \$5,450,117 (5%) for surveillance. The 2000 budget represented a 16 percent increase over the 1999 budget, most of the increase being applied to the medication program for purchase and distribution of the new anti-HIV drugs, the protease inhibitors.

Almost \$41 million, more than 40 percent of the total HIV and STD prevention and services resources were distributed to regional and local health departments and other contracted community-based agencies through prevention and services contracts (See Figure 2). Nearly 46 percent of the total HIV and STD resources were spent providing HIV and STD medications throughout Texas. Other Bureau expenditures included training and public education, regional and central office administrative costs, laboratory costs, travel to support training, technical assistance, and monitoring, supplies and equipment, and public health promotion. Administration encompasses activities such as program planning and development, program evaluation, quality control and technical assistance to contractors, contract monitoring and grants management, and related programmatic and support services. The Bureau also supports the Funding Information Center (FIC) with HIV funds. The FIC researches and disseminates HIV/AIDS-related funding information to the Texas public.

**Figure 2. HIV Prevention and Services Contracts Awarded by PHR  
2000 State and Federal Funds**



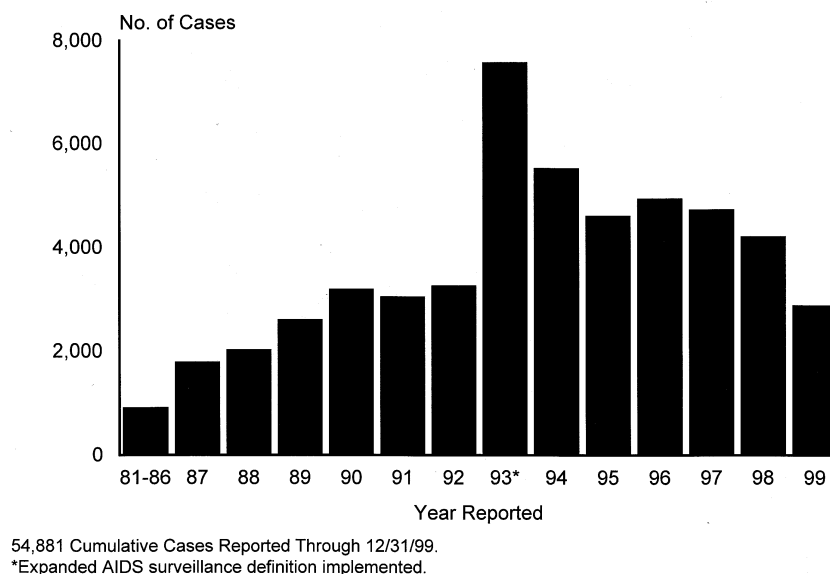


## IV. EPIDEMIOLOGIC ASSESSMENT OF HIV, AIDS, & STDs IN TEXAS

### HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) is the late stage of infection with the human immunodeficiency virus (HIV) and is characterized by severe immunosuppression and co-infection with other opportunistic agents. HIV specifically infects and depletes a subgroup of white blood cells (lymphocytes) called helper T-lymphocytes. These cells are also called CD4+T-cells, which is a term based on laboratory tests that identify these cells by the presence of a specific cell surface marker, CD4. The decline in the number of CD4+T-cells is an indicator of HIV disease progression.

**Figure 3. AIDS Cases by Year of Report**



The CD4+ T-cell count became an important part of the AIDS surveillance case definition that the Centers for Disease Control and Prevention (CDC) revised in 1993. The new case definition of AIDS includes all HIV-infected persons with CD4+ T-cell counts fewer than 200 per microliter of blood, or less than 14% of total lymphocytes. Before this change, the case definition relied on a confirmed positive HIV test and the identification of one of several indicator diseases that commonly occur among immuno-compromised HIV-infected patients. Currently Texas, like many states, is experiencing a decline in AIDS cases. Texas AIDS data is presented in this report in terms of the year the case was reported to TDH, not the year the person was diagnosed with AIDS. From 1996 to 1998 the number of AIDS reports decreased by about 10%, but preliminary analyses indicate that around 32% fewer people were diagnosed with AIDS in 1999 than 1998 (**Figure 3**).

Along with the decline in AIDS cases, the current trend extends to a decline in AIDS deaths. The decrease in AIDS deaths, like the decrease in progression to AIDS, has been generally attributed to the use of triple drug therapy, which delays the progression from HIV infection to AIDS. Although treatment with the triple drug combination is receiving the credit for the decline, other preventive strategies have also entered into the equation: HIV positive individuals are being treated at earlier stages; a variety of therapeutic interventions to prevent secondary infection are available; specific targeting to high-risk groups for early testing and preventive education has increased; and the wider variety of medications to choose from have all created a more favorable prevention strategy.

In Texas, AIDS deaths decreased 20% during the first 6 months of 1998 compared with the first six months of 1997. During the first six months of 1999, AIDS deaths declined only 2% when compared to 1998. The 1999 decline in deaths was confined to White men with a decrease of 15%. The number of deaths for men of other races/ethnicities and for all women either increased or remained the same as in 1998 (**Table 1**).

**Table 1. Texas AIDS Deaths by Race/Ethnicity and Sex, 1999\***

	<b>Jan - June 1997 Deaths</b>	<b>Jan - June 1998 Deaths</b>	<b>Jan - June 1999 Deaths</b>	<b>% Difference in Deaths (98-99)</b>
<b>Males</b>				
White	282	206	175	-15
African American	155	145	145	0
Hispanic	130	96	109	+14
All Others	5	1	1	0
<b>Females</b>				
White	33	17	22	+29
African American	45	49	52	+6
Hispanic	8	15	16	+7
All Others	0	0	0	0
<b>Jan - June Deaths</b>	<b>658</b>	<b>529</b>	<b>520</b>	
<b>Decline in deaths from 1<sup>st</sup> six months of previous year:</b>	<b>45%</b>	<b>20%</b>	<b>2%</b>	

\*1998 deaths based on AIDS database 01/22/99 and 1999 deaths based on AIDS database 1/20/00.

## 1999 Texas AIDS/HIV Statistics

According to the CDC, more than 733,374 persons with AIDS (PWA) have been reported in the US through the end of 1999. By the end of December 1999, Texas had 54,881 PWAs reported since the start of the epidemic in the early 1980s. At least 28,777 of these PWAs are deceased. Texas ranked fourth highest in the US with 2,865 AIDS cases reported in 1999. In 1998, AIDS fell from fourth to fifth in leading causes of death among Texas males aged 35 to 44, while it remained the fourth leading cause of death among the 25 to 34 age group. In 1998, HIV infection ranked ninth among causes of deaths for African Americans (both male and female). HIV/AIDS was not ranked in the top ten causes of death for other racial/ethnic groups in Texas. The overall AIDS rate for Texas in 1999 was 14.3 cases per 100,000 population. For Texas males, the 1999 AIDS rate, (23.6 per 100,000), remained much higher than the female AIDS rate (5.2 per 100,000). The Texas male HIV (not AIDS) rate for 1999 was 20.1 cases per 100,000 population, while the female HIV rate of 8.8 cases per 100,000 population demonstrated the increasing spread of new infections among women (**Table 2**).

**Table 2. AIDS Cases Reported by Race/Ethnicity\* and Sex, 1999**

<b>Sex/Race</b>	<b>Cases</b>	<b>%**</b>	<b>100,000</b>
<b>Males</b>			<b>23.6</b>
White	958	41	17.7
African American	772	33	70.4
Hispanic	592	25	19.2
All Others	14	<1	—
<b>Female</b>			<b>5.2</b>
White	132	25	2.3
African American	286	54	24.1
Hispanic	107	20	3.6
All Others	4	<1	—
<b>Total Cases</b>	<b>2,865</b>	<b>100.0</b>	<b>14.3</b>

\*The category All Others includes any racial/ethnic group not listed as well as those cases not specifying race.

Therefore, a rate is not calculated.

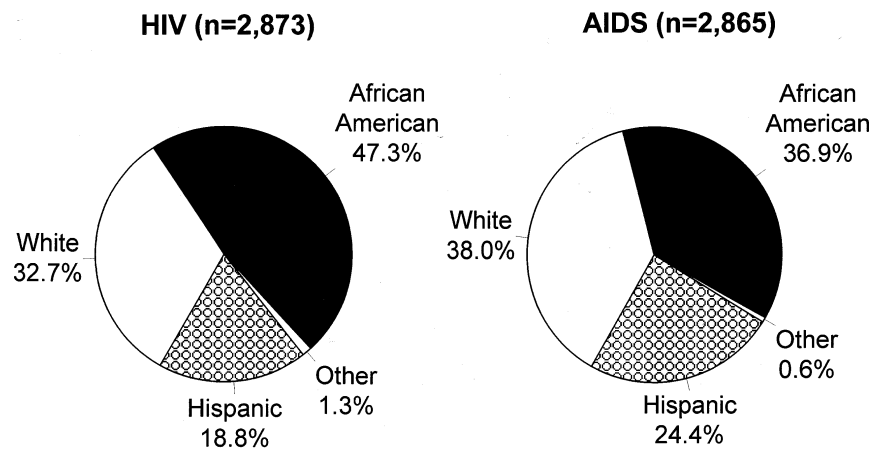
\*\*Percentages may not total 100% due to rounding.

## Rates by Sex and Race/Ethnicity

Of the 2,865 AIDS cases reported in Texas in 1999, the racial/ethnic distribution was fairly even numerically among Whites (38%), African Americans (37%) and Hispanics (24%)(**Figure 4**). However, the rate of reported AIDS cases in 1999 among Texas' African Americans (46.4 per 100,000 population) was more than four times higher than the rates for Whites (9.9 per 100,000) or Hispanics (11.5 per 100,000). Although the Texas case rate for females was 5.2 AIDS cases per 100,000, the African American female rate was much higher at 24.1 cases per 100,000. The Hispanic and the White female rates were lower at 3.6 cases per 100,000 and 2.3 cases per 100,000, respectively. The Texas African American male population had the highest rate at 70.4 cases per 100,000, followed by Hispanic males at 19.2 cases per 100,000 and White males at 17.7 cases per 100,000 (**Table 2**).

The racial/ethnic distribution for the 2,873 HIV cases reported in 1999 was 47% African American, 33% White, and 19% Hispanic (**Figure 4**). The HIV data clearly demonstrate the movement of the epidemic further into the minority communities. The rate of reported HIV cases in 1999 among African Americans (59.5 per 100,000) was more than six times higher than the rates for Whites (8.5 per 100,000) or Hispanics (8.9 per 100,000). Although the Texas case rate for all females was 8.8 cases per 100,000, the African American female rate was much higher at 45.5 cases per 100,000. The Hispanic and the White female rates were lower at 4.5 cases per 100,000 and 3.6 cases per 100,000, respectively. The Texas African American male population had the highest HIV rate with 74.7 cases per 100,000, followed by White males at 13.6 cases per 100,000 and Hispanic males at 13.1 cases per 100,000 (**Table 3**).

**Figure 4. HIV & AIDS Cases by Race/Ethnicity 1999**



**Table 3. HIV (not AIDS) Cases Reported by Race/Ethnicity\* and Sex, 1999**

Sex/Race	Cases	% **	Cases per 100,000
<b>Males</b>			<b>20.1</b>
White	736	37	13.6
African American	819	41	74.7
Hispanic	404	20	13.1
All Others	27	<1	—
<b>Females</b>			<b>8.8</b>
White	203	23	3.6
African American	540	61	45.5
Hispanic	135	15	4.5
All Others	9	<1	—
<b>Total Cases</b>	<b>2,873</b>	<b>100.0</b>	<b>14.4</b>

\* The category All Others includes any racial/ethnic group not listed as well as those cases not specifying race. Therefore, a rate is not calculated.

\*\*Percentages may not total 100% due to rounding.

## HIV Reporting

The time from initial infection with HIV until a person develops an AIDS-defining condition may span years; therefore, AIDS case reports do not include those recently infected. HIV infection reports tend to identify more recently infected individuals than do AIDS case reports. For health professionals to follow the current trends of HIV disease and to develop prevention strategies, prompt identification and reporting of HIV infections is essential.

HIV reporting is critical to the accurate and timely assessment of disease trends. As mentioned earlier, new drug treatments now available to HIV-infected patients delay the decline of CD4+T-cell counts and delay the progression to an AIDS-defining condition for these individuals. These developments will reduce the usefulness of AIDS case data for analyzing the epidemic and increase the need for better HIV reporting. The CDC has been encouraging all states to develop reliable HIV surveillance systems because the AIDS case reporting system is no longer adequate to track the HIV/AIDS epidemic. In 1998, Texas initiated discussions in the community regarding the implementation of an HIV surveillance system for statewide reporting to enable the State to begin better tracking of HIV incidence, prevalence and trends. In January 1999, the Bureau implemented HIV reporting by name. The hope is that this will enable the State to provide more timely services to HIV-infected persons and more effective preventive education. In December 1999, the CDC revised the surveillance case definition for HIV infection. Most notable to the revision, was the inclusion of viral load quantities in reporting positives. As a result of the definition change, effective January 1, 2000 TDH reporting rules require that laboratories and providers report positive results along with detectable quantities found in viral load tests.

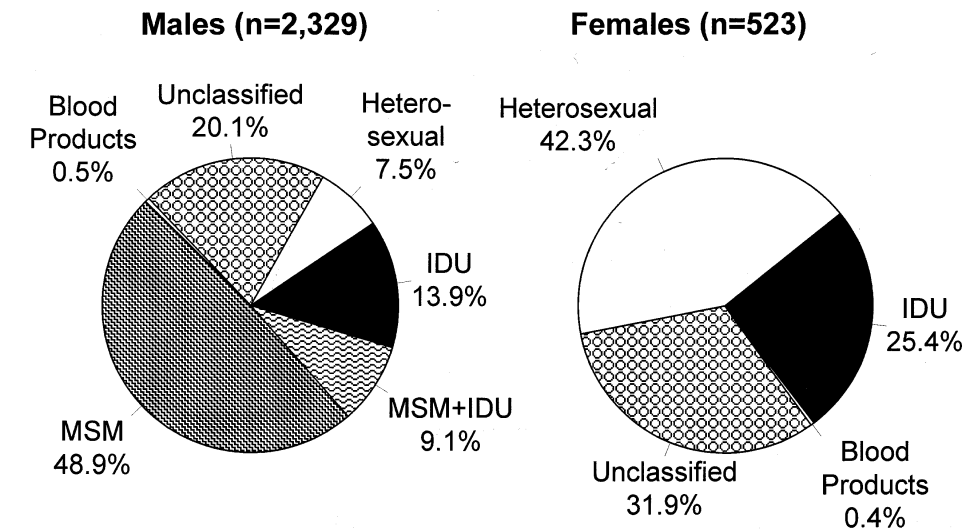
## Modes of Exposure

Although lower than in previous years, the Men Who Have Sex with Men (MSM) exposure category constituted close to half (49%) of the 1999 AIDS cases among Texas men (**Figure 5**). Additionally, Injecting Drug Use (IDU) was the most likely route of transmission for 14% of men reported with AIDS. The MSM + IDU category constituted 9% of the cases among males, and the Heterosexual route of transmission was reported for 8% of men with AIDS. Among women, the Heterosexual exposure category was identified for 42% and the use of injecting drugs was designated as the mode of exposure for 25%. A higher percentage of cases among women (32%) than men (20%) were initially unclassified as to mode of exposure. For both sexes, the percentage of cases that remain unclassified will decrease over time as the investigations of risk are completed. However, due to the definition of heterosexual contact used by the CDC, only those individuals whose risk for HIV infection is heterosexual sex with a known HIV infected partner are classified as “heterosexually acquired.” Those individuals whose risk is heterosexual sex with partners whose HIV status is unknown, remain unclassified.

For HIV infections, the MSM exposure category constituted less than half (44%) of HIV cases among Texas men. Additionally, IDU was the most likely route of transmission for 16% of men reported with HIV. The MSM + IDU category constituted 11% of the HIV cases among males, and

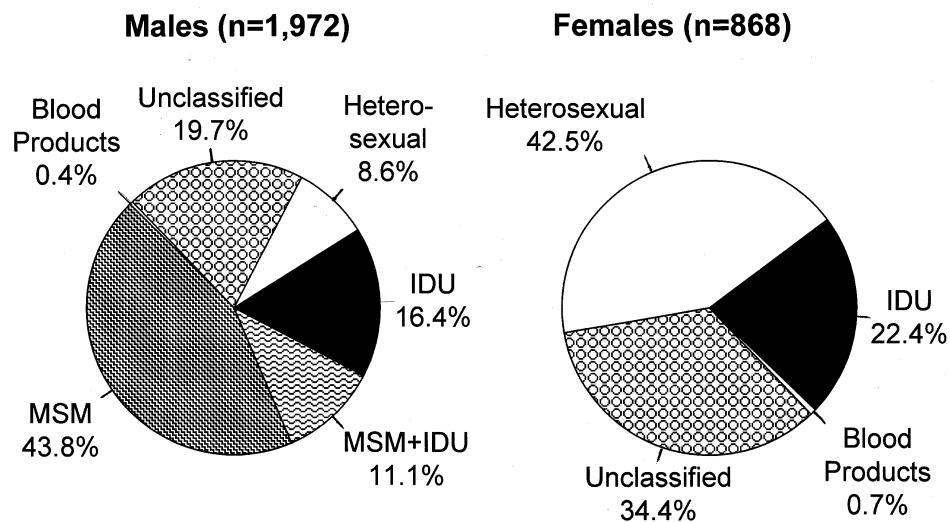
the heterosexual route of transmission was reported for 9% of men with HIV. Among women, the heterosexual exposure category was identified for 43% and the use of injecting drugs was designated as the mode of exposure for 22%. As with AIDS cases, a higher percentage of HIV cases among women (34%) than men (20%) were initially unclassified as to mode of exposure. Many of these likely represent heterosexually acquired cases (**Figure 6**).

**Figure 5. Adult-Adolescent AIDS Cases by Mode of Exposure and Sex**



\*Age 13 or older at time of diagnosis

**Figure 6. Adult-Adolescent HIV Cases by Mode of Exposure and Sex**



\*Age 13 or older at time of diagnosis

## Geographic Distribution

Most AIDS cases in Texas continue to be reported from metropolitan areas. The largest number of cases reported in 1999 were from Harris County (680) followed by Dallas (536), Travis (247), Bexar (204), Tarrant (134), and El Paso (87) Counties. Ranking these counties by rate changes the order with Travis County the highest (38.2 cases per 100,000), followed by Dallas (24.7), Harris (20.8), Bexar (15.0), El Paso (11.5) and Tarrant (8.9). The Texas Department of Criminal Justice reported 8.2% of all 1999 AIDS cases (236). In 1999, 141 counties out of the 254 in Texas reported at least one AIDS case. Although still centered mainly in the metropolitan areas of the state, the HIV epidemic continues to spread into more rural areas, requiring all counties to face the challenges of providing HIV prevention education, health care, and services.

Reports of HIV cases in Texas are also reported predominantly from metropolitan areas. These case reports may be skewed, however, since some areas of the state were more prepared than other areas to begin reporting HIV cases at the start of 1999. The largest number of cases reported in 1999 were from Harris County (918) followed by Dallas (551), Bexar (153), Tarrant (127), Travis (116), and El Paso (55) Counties. Harris County had the highest HIV rate (28.1 cases per 100,000) followed by Dallas (25.4), Travis (17.9), and Bexar (11.2) counties. The rates for El Paso and Tarrant Counties were 7.3 and 8.4 cases per 100,000 population, respectively. In 1999, 110 counties out of the 254 in Texas reported at least one new HIV case. The Texas Department of Criminal Justice reported 13.5% (387) of all HIV cases in 1999.

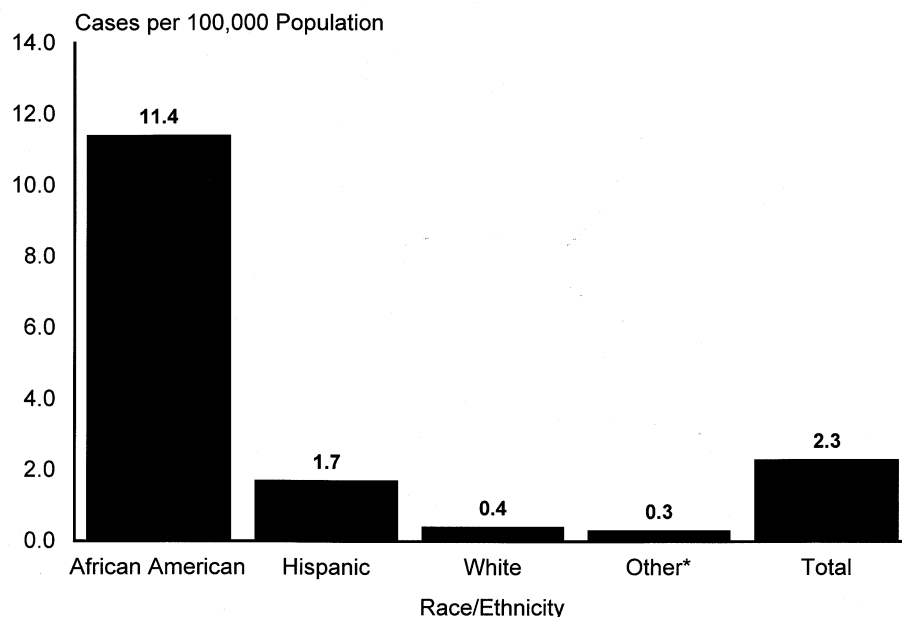
# Sexually Transmitted Diseases

## Primary and Secondary Syphilis

The spirochete (*Treponema pallidum*) causes syphilis. The acute form of the disease, Primary and Secondary (P&S) syphilis, is characterized by initial lesions (an ulcer or chancre at the site of infection) followed by secondary manifestations that include rash, mucocutaneous lesions, and adenopathy. Untreated P&S syphilis progresses into a chronic disease with long periods of latency. Statewide, 459 cases of P&S syphilis were reported in 1999. This 7% increase from cases reported in 1998 reverses a seven-year downward trend. Still, the number of P&S syphilis cases reported in 1999 was one-tenth the number reported in 1991. More than 25% of P&S patients were between 15 and 24 years of age. Unlike previous years where cases were distributed more equally among sexes, men accounted for 61% of reported cases in 1999.

The overall state rate in 1999 for P&S syphilis was 2.3 cases per 100,000 population. African Americans continued to account for the majority (57%) of P&S syphilis cases reported in Texas in 1999. The rate of P&S syphilis among African Americans was 11.4 cases per 100,000 population. Although less than one-fourth the 1995 rate of 53.2, the rate for African Americans remained extremely high compared with rates for Hispanics (1.7 cases per 100,000 population) and Whites (0.4

**Figure 7. Primary and Secondary Syphilis Rates by Race/Ethnicity**



\* Excludes cases of unspecified race/ethnicity



cases per 100,000) (**Figure 7**). Among African American women, those aged 20 to 24 had the highest rate at 29.5 cases per 100,000 population. In contrast, the highest rate for African American men was found among those aged 35 to 39 with 35.4 cases per 100,000. African American men also had P&S syphilis rates of at least 20 cases per 100,000 across a wide range of age groups (20 to 24, 25 to 29, 30 to 34, and 40 to 44 years of age). The extremely high case rate for both sexes indicates that P&S syphilis continues to be a significant problem among African Americans in Texas.

Despite the overall decline in the number of P & S syphilis cases in Texas over the past eight years, certain geographic areas of the state continue to experience high rates of the disease. Two metropolitan areas, Dallas and Harris counties, continue to meet the Center for Disease Control and Prevention's definition of High Morbidity Areas (HMAs). In accordance with the CDC's national plan to eliminate the disease from the U.S., the Bureau of HIV and STD Prevention has implemented a Syphilis Elimination Project for the state of Texas. TDH receives approximately \$480,000 in federal funds to support the Syphilis Elimination Project.

## Early Latent Syphilis

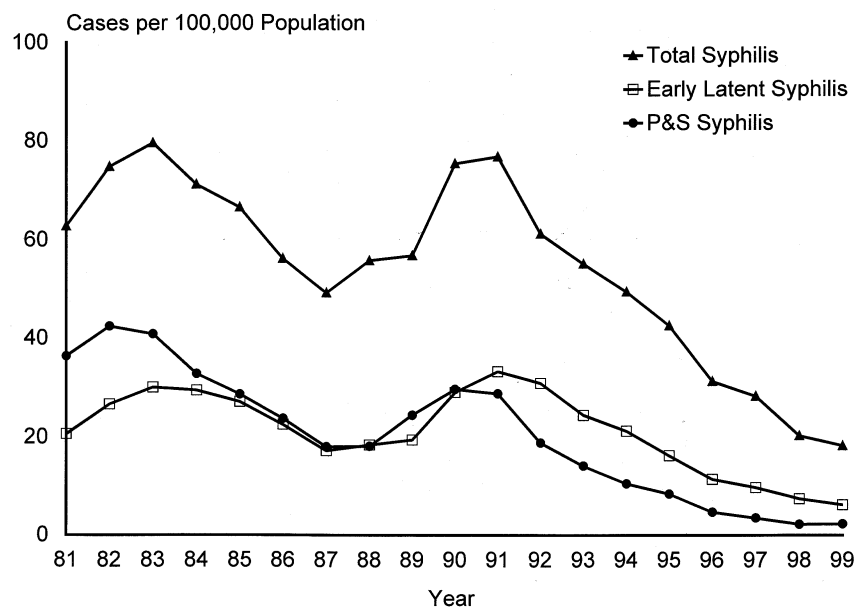
The early latent stage of syphilis is defined as the first year following secondary syphilis. Untreated cases of more than one year's duration or of unknown duration are classified as late latent syphilis. In both early and late latent stages, positive clinical signs are absent, and detection of syphilis relies upon serologic tests. Tertiary syphilis is symptomatic late disease which may include neurologic and cardiovascular sequelae. The late latent and tertiary stages of syphilis are not discussed separately in this article because those individuals contracted the disease many years prior to their cases being diagnosed and reported, and syphilis is not as likely to be communicable in these late stages. Thus, there are limited public health implications to these diagnoses.

In 1990, slightly over 5,000 cases of P&S and of early latent syphilis were reported with similar rates of 30.4 and 29.9 cases per 100,000 population, respectively. The rate of P&S syphilis steadily declined from 1990 to 1998, however, the early latent syphilis rate increased in 1991 and since then has decreased more slowly than the P&S syphilis rate (**Figure 8**). This delayed decline of early latent syphilis rates is typical of periods of decreasing syphilis morbidity. Although both P&S syphilis and early latent syphilis cases were considerably lower in 1999 compared with 1990, the number of early latent syphilis cases (1,240) was nearly three times the number of P&S syphilis cases. The 1999 overall rate of early latent syphilis was 6.2 cases per 100,000 population. The incidence rates for early latent syphilis by race/ethnicity were as follows: African Americans, 31.8 cases per 100,000; Hispanics, 5.4; Whites, 1.4.

## Congenital Syphilis

Congenital syphilis, one of the most serious forms of the disease, may cause abortion, stillbirth, or premature delivery, as well as numerous severe complications in the newborn. In 1999, 92 cases of congenital syphilis were reported, marking the sixth year of decline: the number of congenital

**Figure 8. Syphilis Rates, Texas 1972-1999**



syphilis cases in 1999 represented a 7% decrease from 1998. With 47 cases, Harris County had the highest number of congenital cases, a small decline from the 51 cases reported from that county in 1998. Hidalgo County had the second-highest number with 14 cases. Dallas County, the second-highest in congenital syphilis reports for 1998, dropped from 23 cases in 1998 to only 4 in 1999. Statewide, 52% of congenital cases were among Hispanics, 37% among African Americans, and 10% among Whites. Based on 1998 live birth numbers (1999 birth data was unavailable), the estimated rate of congenital syphilis in 1999 was 30 cases per 100,000 live births.

## Total Syphilis

The term ‘total syphilis’ refers to all reported syphilis cases regardless of the stage of the disease. Included in this total are congenital, P&S, early latent, late latent, and tertiary syphilis. In 1999, 3,647 cases of total syphilis were reported, for a statewide rate of 18.2 cases per 100,000 population. This marks the eighth year of decline in total syphilis numbers, closely paralleling the decreases seen among P&S and early latent syphilis (**Figure 8**).

## Chlamydia

The bacteria (*Chlamydia trachomatis*) is one of the most common causes of sexually transmitted infections. Chlamydia infection in women can result in serious complications such as pelvic inflammatory disease and ectopic pregnancy. After chlamydia became reportable in 1987, the number of cases soared, reflecting increased testing but not necessarily increased disease. Reports of chlamydia in 1999 totaled 62,526, a 3% increase from the previous year’s total of 60,626. In 1997 and 1998, Texas experienced much larger increases in chlamydia reports. At the time, these increases were attributed to the state-wide implementation of new morbidity surveillance software, Sexually

Transmitted Disease Management Information System (STD\*MIS), which allowed for more complete capture of morbidity data. The leveling out of chlamydia numbers in 1999, following the establishment of STD\*MIS, seems to support that theory.

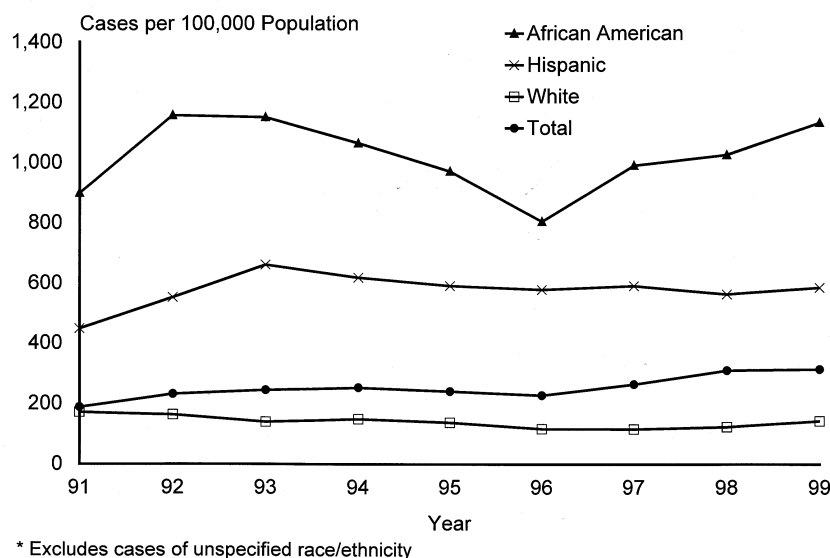
Statewide the total number of clients screened for chlamydia through public funding decreased from 349,517 in 1998 to 337,832 in 1999; the number of positives resulting from these screenings, however, increased from 23,707 in 1998 to 26,145 in 1999.

Of the total chlamydia cases reported in 1999, 83% were among women. Women are more likely to be screened for chlamydia during clinical exams for family planning, prenatal care, and routine pap smear testing. Because of the increased risk of severe outcomes, including the potential for pelvic inflammatory disease and the possibility of infecting a newborn child, chlamydia screening programs almost always focus on women. Men are often asymptomatic and therefore do not seek treatment. Given that men make up such a small proportion (17%) of chlamydia cases reported, it is not possible to estimate the true incidence of chlamydia in the Texas population.

Because women accounted for the vast majority of chlamydia reports, rates for each sex should be examined separately. The 1999 case rate for women was 511 cases per 100,000 population with African American women having the highest rate (1,132 cases per 100,000), followed by Hispanic (585) and White women (142) (**Figure 9**). Men showed a similar racial/ethnic distribution to women but with far lower rates. However, because the majority of individuals with chlamydia are asymptomatic, equal targeting of men for screening and testing would likely result in a higher incidence than was suggested by case reports.

Over 74% of all reported chlamydia patients were 15 to 24 years of age, with over 39,000 cases reported for women aged 15 to 24 alone. The rates for chlamydia among women aged 15 to 19 and 20 to 24 were 2,928 cases and 2,547 cases per 100,000 population, respectively.

**Figure 9. Chlamydia Rates for Females, Texas 1991-1999**



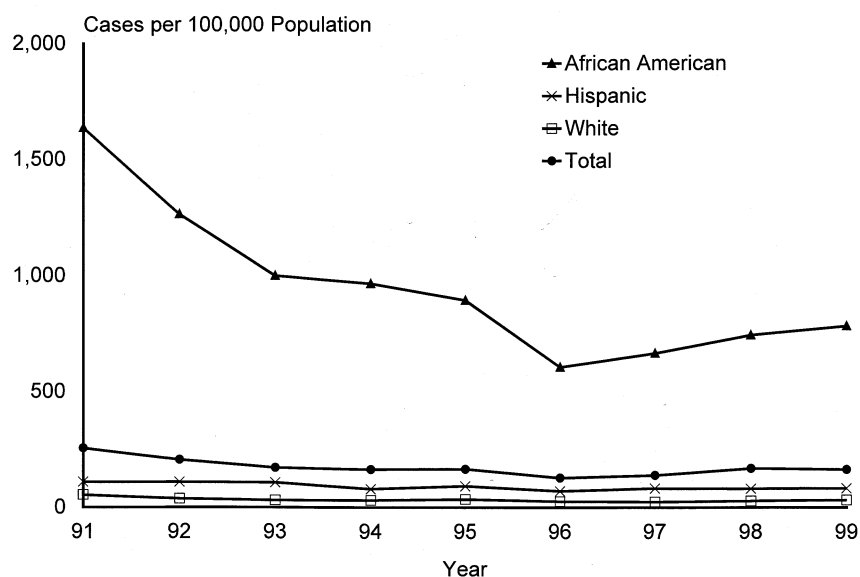
## Gonorrhea

The bacteria (*Neisseria gonorrhoeae*) causes gonorrhea. Left untreated, gonorrhea may lead to sterility in men and pelvic inflammatory disease, ectopic pregnancy, and sterility in women. The 32,680 cases of gonorrhea reported in 1999 represent less than a 1% decrease from the number of cases reported in 1998. As with chlamydia, gonorrhea numbers had increased substantially in both 1997 and 1998 prior to leveling off in 1999; the conversion to STD\*MIS surveillance software was likely also responsible for these gonorrhea trends. The 1999 state rate for gonorrhea was 163 cases per 100,000 population, slightly lower than the rate in 1998 (169 cases per 100,000). The rate among women in 1999 (165 cases per 100,000) was only slightly higher than the rate for men (161 cases per 100,000) and both rates have been nearly the same since 1996.

The gonorrhea rate for African Americans (783 cases per 100,000) was nearly 10 times greater than the rate for Hispanics (83 cases per 100,000) and nearly 25 times higher than the rate for Whites (32 cases per 100,000)(**Figure 10**). African American men had the highest rate of all race/ethnicity-sex groups at 877 cases per 100,000 population. Gonorrhea cases among African Americans aged 15 to 24 accounted for the greatest share of African American cases (64% of those reported); they also represented 35% of all cases reported regardless of race/ethnicity or age.

Among age groups, the highest rate for women was found in those aged 15 to 19 (937 cases per 100,000) followed by those aged 20 to 24 (740 cases per 100,000). Men in these age groups also had higher rates at 450 cases per 100,000 for the 15 to 19 age group and 665 per 100,000 for those 20 to 24. Gonorrhea among young women aged 15 to 24 comprised 72% of all cases in women; young men in this age group accounted for 53% of all gonorrhea cases among men. In 1999, young men and women aged 15 to 19 accounted for 32% of gonorrhea, compared with 30% in 1998 and 27% in 1997.

**Figure 10 Gonorrhea Rates for Females, Texas 1991-1999**



\* Excludes cases of unspecified race/ethnicity

Statewide the total number of publicly-funded screenings decreased 4% from 350,643 in 1998 to 338,181 in 1999; at the same time the number of positive results from these tests increased 12% from 13,930 in 1998 to 15,611 in 1999.

## Pelvic Inflammatory Disease (PID)

PID is a serious, sometimes life-threatening complication of untreated chlamydia and gonorrhea in women. Acute PID caused by chlamydia and gonorrhea increases a woman's risk of recurrent PID, chronic pelvic pain, ectopic pregnancy and infertility. In 1999, 1,766 cases of PID were reported, a 5% decrease from the 1,861 cases reported in 1998. PID cases attributed to chlamydia or gonorrhea accounted for 52% of the cases reported in 1999, 44% were cases of unknown etiology. Chlamydial PID case reports rose from 487 in 1998 to 531 in 1999, gonococcal PID case reports were nearly unchanged with 399 in 1998 and 391 in 1999. New surveillance software (STD\*MIS) was the most likely explanation for increases in PID from 1997 to 1998 and the leveling of reports in 1999. The racial/ethnic breakdown of PID resembles that of other STDs with African American women accounting for 48% of all cases, Hispanic women for 30% and White women for 18%. Young women aged 15 to 24 accounted for 61% of all PID cases in 1999.



## Sexually Transmitted Diseases Among Adolescents

Compared to older adults, adolescents (10 to 19 year-olds) and young adults (20 to 24 year-olds) are at higher risk for acquiring STDs for a number of reasons: they may be more likely to have multiple (sequential or concurrent) sexual partners rather than a single, long-term relationship; they may be more likely to engage in unprotected intercourse; and they may select partners at higher risk. In addition, for some STDs, for example (*Chlamydia trachomatis*), adolescent women may have a physiologically increased susceptibility to infection due to increased cervical vulnerability. During the past two decades, the age of initiation of sexual activity has steadily decreased and age at first marriage has increased, resulting in increases in premarital sexual experience among adolescent women and in an enlarging pool of young women at risk.

The total burden of STDs is estimated at 12 million new infections annually in the United States. Studies indicate that people are two to five times more likely to become infected with HIV when other STDs are also present. The open lesions of herpes and syphilis allow a portal of entry for HIV viruses, while the inflammatory and mucopurulent nature of gonorrhea and chlamydia provide numerous target cells (CD4 cells) for increasing susceptibility. Generally, about two-thirds of all STD infections occur among persons under 25 years of age and predominantly among minority populations. Prevalence studies in various clinic populations and large-scale screening projects have consistently demonstrated that younger women have higher positivity rates of chlamydia than older women.

Of the 108,903 cases of all STDs reported in Texas in 1999, 66% were among those 15 to 24 years old, over 34% of these cases were from adolescents aged 15 to 19 (**Figure 11**). Minority youth

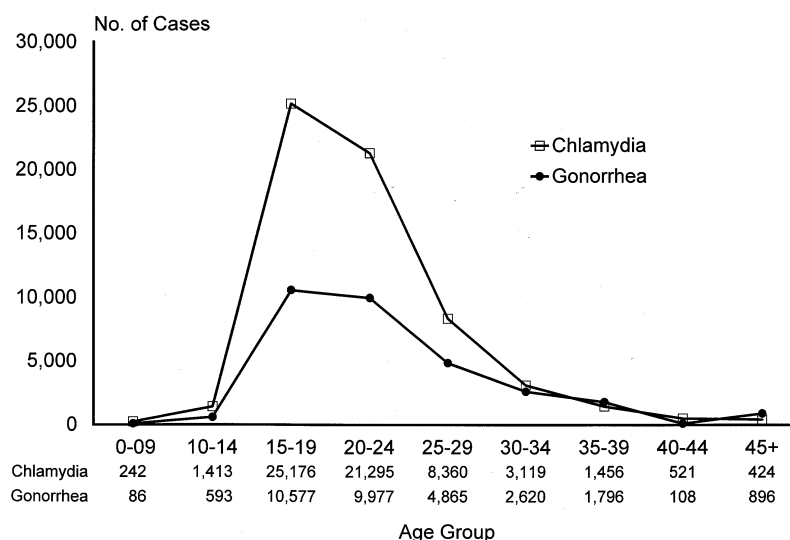


make up a disproportionate share of these STD cases. The 1999 STD case reports that included ethnicity information for those aged 15 to 19, 48% were African American, 34% were Hispanic, and were 18% White. The STD case rate for African Americans aged 15 to 19 was 10 times higher than the rate among Whites, and the rate for Hispanic adolescents was more than twice the White rate.

Gonorrhea cases reported in 1999 among those aged 15 to 19 numbered 10,577 and accounted for 32% of all gonorrhea cases. The case rates for this age group was 2,890 cases per 100,000 population for African Americans, 324 per 100,000 for Hispanics, and 150 per 100,000 for Whites. Chlamydia cases reported in 1999 numbered 25,176 for this age group and accounted for over 40% of all cases reported. The chlamydia case rates for those aged 15 to 19 were 3,853 cases per 100,000 population among African Americans, 1,421 per 100,000 for Hispanics, and 535 per 100,000 for Whites. The true incidence of chlamydia may be much higher because it is usually asymptomatic and detected only by the screening of those seeking medical care for other reasons.

The annual direct medical cost of STD treatment is estimated at over 8.4 billion dollars annually. For Texas, the cost of treating uncomplicated STDs for those 15 to 19 years of age in 1999 was at least \$2.5 million. Every dollar spent in Texas for the prevention of STDs saves ten dollars in medical costs. Although young people have a greater risk of being infected with an STD other than HIV, these “traditional” STDs receive less attention than HIV. Prevention methods for both HIV and STDs overlap, but teaching adolescents to recognize the symptoms of traditional STDs and to seek treatment early may prevent more severe forms of the diseases from developing. Educational programs and preventive messages need to be developed and delivered by parents, teachers, religious leaders, youth leaders, professionals working with adolescents, peers, media, and role models. Young people themselves, serving as peer educators, should be enlisted and relied upon as an important part of all STD prevention efforts.

**Figure 11. Chlamydia and Gonorrhea Cases Reported By Age Group, 1999**



## V. HIV PREVENTION AND SERVICES

The three components of the HIV Prevention program are Health Education and Risk Reduction (HERR), Prevention Counseling and Partner Elicitation (PCPE), and Public Information. All components of the prevention program are planned through a community planning initiative mandated by the CDC in 1993.

### COMMUNITY PLANNING

Community planning is the process that enables local communities to identify, plan, and determine prevention priorities within their regions. Community planning in Texas has evolved from a single decision-making body heavily influenced by TDH, to a body of ten HIV Prevention Regional Planning Coalitions (Coalitions), to a partnership with six Coalitions that represent the geographic and cultural diversity of Texas. The Coalitions are responsible for determining community priorities and intervention strategies based on local and regional needs assessment. The Coalitions and the TDH jointly develop a comprehensive HIV prevention plan that identifies populations with the highest rates of HIV infection and prioritizes interventions and strategies to prevent HIV infection in identified populations. The TDH uses this plan to allocate HIV prevention funds through a competitive Request for Proposal Process.



The goal for each Coalition is to include members who represent the unique profile of affected populations within its jurisdiction. An open nomination process for membership ensures parity, inclusion and representation from those most affected by HIV. The Coalitions include those who are affected, infected and at highest risk for HIV infection, persons with expertise in social and behavioral science, epidemiology, and HIV prevention interventions, and local HIV prevention workers. Members of the Coalitions represent the cultural, ethnic and other diversities of the Texas population most affected by HIV and AIDS within the Coalition jurisdiction.

The Coalitions completed a two-year planning cycle (1997-1998) in September of 1998. During this planning cycle, the Coalitions reviewed epidemiologic and needs assessment data, behavioral science literature on prevention interventions, and completed a priority setting process to develop the Regional Action Plans. The 1999 Comprehensive HIV Prevention Plan submitted to the CDC in October of 1998 for implementation years 1999 through 2002 is a compilation of the ten Regional Action Plans.

## **Accomplishments**

- ❖ TDH increased technical assistance to Coalitions to improve their ability and capacity to produce regionally representative HIV prevention plans. The technical assistance included training in infrastructure development, assistance in analysis of epidemiologic data, guidance on applying behavioral science theory to prevention interventions, and data collection methods. TDH Planning Staff trained the Health Education Training Centers Alliance of Texas to provide the majority of technical assistance directly to Coalitions.
- ❖ The Coalitions and TDH in partnership developed a process to redesign their geographical structure and regional planning jurisdictions. The purpose of restructuring Coalitions is to enhance their capacity to perform multiple and complex planning processes; and to assist rural Coalitions in maintaining parity, inclusion and representation in the process.
- ❖ Members of the Community Planning Coalitions attended the National HIV Prevention conference in Atlanta and gained information critical to the development of HIV Prevention interventions.
- ❖ Community Planning Coalition members participated in a workgroup to develop a framework for new bylaws.

## **Future Plans**

The following goals were adopted for the community planning process in Texas for 1999, 2000 and 2001. Since these goals are long-term, the 1999 planning year was crucial in implementing first steps toward meeting these goals:

- ❖ Improve the needs assessment process by developing minimum standards for collecting qualitative and quantitative data on subpopulations and resource inventory data on existing programs.
- ❖ Strengthen the infrastructure of Coalitions by maximizing technical assistance resources including the use of current technology.
- ❖ Collaborate with Ryan White Title I Planning Councils, Ryan White Title II Consortia, and other HIV/STD planning groups by exchanging information and by mutual participation in local planning activities.
- ❖ Integrate STD resources and expertise in the development of comprehensive HIV prevention priorities in the regional action plans.
- ❖ Adherence to the parity, inclusion and representation guidelines by all Coalitions.
- ❖ Ensure that coalitions have access to expertise in epidemiology, behavioral science, health planning, and evaluation, as well as STD expertise.



## HEALTH EDUCATION AND RISK REDUCTION

The goal of the Health Education and Risk Reduction (HERR) component is to educate persons at high risk for HIV about disease transmission, assist them in establishing realistic and personalized risk reduction plans, and to provide them with the skills needed to remain HIV free. During 1999, TDH staff developed and managed a competitive application and review process for selecting HERR contractors who began providing these services for their communities in January 1, 2000. This competitive application was based on plans developed by the ten community planning groups, using the process outlined in the previous section.

During 2000, both local health departments and community-based organizations provided HERR services. These contractors targeted one or more of the specific populations named in their Regional Action Plan (e.g., African-American injection drug users, men who have sex with other men, women at risk through heterosexual transmission, etc.), and provided these populations with educational interventions with demonstrated effectiveness that were culturally sensitive, language-appropriate, and appropriate to the settings in which the clients are encountered. In keeping with the guidance provided by the communities' plans, the majority of the HERR direct delivery staff were peers to the populations they served<sup>1</sup>, which helps establish and maintain the rapport necessary for effective communication. They conducted activities in a variety of sites, such as community hangouts, streets, parks, local jails, STD clinic waiting rooms, local health department clinics, and other local agencies.

TDH staff also provide technical programmatic assistance, as well as conduct monitoring of HERR contractors. In addition, TDH staff provide technical assistance to organizations to help them evaluate their programs and demonstrate the effectiveness of their interventions. This ensures that contractors are effective in their implementation of HIV prevention interventions and that contract dollars are spent in accordance with accepted contract objectives. Another important role of this component is to provide ongoing information and HIV educational material to both contractors and non-contractors for distribution to the general public.

### Accomplishments

- ❖ HERR contractors provided over 210,000 educational contacts to gay men, injection drug users, and high-risk heterosexuals in a variety of community-based settings. Contractors exceeded objectives in all categories of behaviorally-defined target populations.
- ❖ HERR contractors also provided nearly 150,000 skills-building contacts to gay men, injection drug users, and high-risk heterosexuals in a variety of community-based settings. Contractors exceeded objectives in all categories of behaviorally-defined target populations.

<sup>1</sup> Peer means that the worker was either a member of the group being targeted (e.g., gay man, former injection drug user, Hispanic woman) or is sensitive to and experienced with the issues affecting that population.

- ❖ HERR contractors dispensed over 3.6 million condoms throughout the State.
- ❖ TDH staff began to utilize data collected from the new system for reporting contacts made during HERR activities for analysis of gaps in coverage of HERR programs and to identify additional areas of high-priority for HERR based interventions. TDH staff provided technical assistance to contractors regarding the use of the new system to assist contractors at improving their ability to reach at-risk populations, particularly those who are difficult to reach (i.e. IDU).

## **Future Plans**

- ❖ TDH will continue to direct HERR contractors to provide HERR interventions in outreach settings and to have peers of the targeted population providing these interventions. Peer outreach will be conducted in locations identified in Regional Action Plans where high-risk activity takes place or where members of the populations being targeted congregate. In addition to individual level interventions, group and community level interventions will be undertaken.
- ❖ With the cooperation of evaluation contracts with the University of Texas, Houston, School of Public Health and the University of Texas Southwest Medical School, TDH will develop methods to evaluate HERR interventions and programs for quality improvement and to assist in demonstrating the effectiveness of activities, and the cost-effectiveness of these prevention programs and provide technical assistance on the adaptation and dissemination of effective prevention programs throughout the state.

## **PREVENTION COUNSELING AND PARTNER ELICITATION**

TDH provides Prevention Counseling and Partner Elicitation (PCPE) services throughout the State through contracts with local health departments and community-based organizations. Prevention counseling is client-centered, interactive and responsive to individual client needs. The focus of prevention counseling is on developing prevention goals and strategies with the client rather than simply providing information. Counselors must understand the unique circumstances of each client (e.g., behaviors, sexual orientation, race/ethnicity, culture, knowledge level, social and economic status). Counselors engage clients in Test Decision Counseling, a process to help clients reach their own decisions about whether to test for HIV, which includes assessing and supporting client readiness for testing and coping with the results.

When clients return to learn their test results, they always receive personal post-test prevention counseling. If the client tests negative for HIV infection, results counseling reinforces behavior changes identified by the client to keep from becoming infected. If the client tests positive for HIV, post-test counseling encompasses a range of issues. Prevention counselors provide referrals to link HIV positive clients with medical, psychological and social services. They also elicit the names of

sex and/or needle sharing partners in order to assist the client in ensuring these partners are notified of their potential exposure to HIV and offered the opportunity to receive counseling and learn their HIV status. Trained Disease Intervention Specialists at local health departments or the clients may conduct these notifications. Finally, post-test counseling reinforces behavior changes the client has identified to maintain personal health and prevent transmitting the infection.

TDH staff provides technical assistance to contractors and monitors contracts to ensure compliance with objectives and appropriate use of program funds. Additionally, the PCPE component maintains data collection and reporting systems that provide important information for planning and implementing prevention activities. Each time an initial counseling session is done with a client, the counselor fills out a standard machine-scannable bubble form that contains demographic and mode of exposure<sup>2</sup> information about the client, as well as information about the counseling session (e.g., date, if HIV test was performed, result of HIV test, if client returned for follow up counseling). These forms are submitted to TDH, where they are compiled and analyzed, and the data are forwarded to the CDC in Atlanta.

In 1999, contractors reported 123,640 initial counseling sessions. Fifty-three percent (53 percent) of these sessions were with male clients, and 47 percent with females.

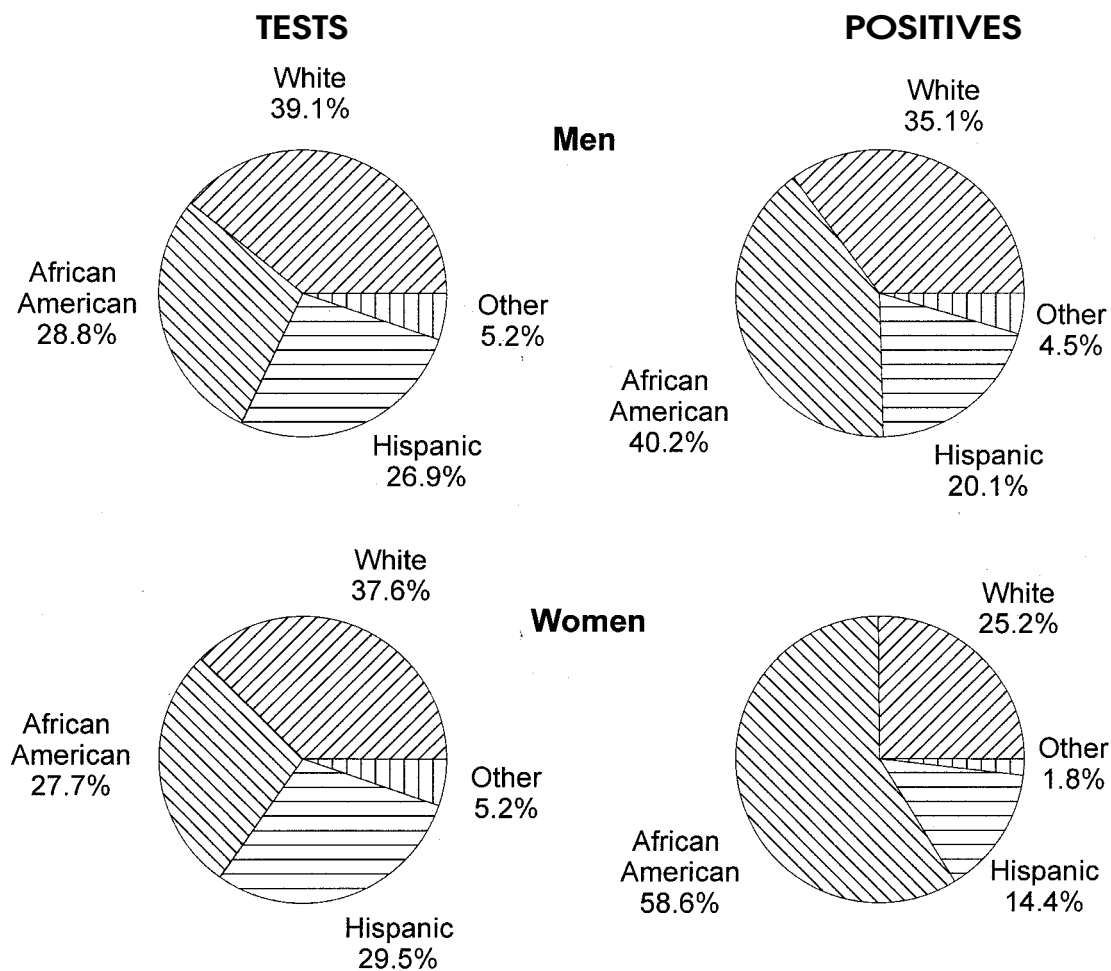
During 1999, 96 percent of the initial counseling sessions included an HIV test. Of these tests, 40 percent were for clients who had never tested for HIV before. For every 100 tests performed, 1.0 were HIV positive. This rate is similar to the positivity rate reported in 1998. The race/ethnicity and mode of exposure of the men and women who tested and who tested positive for HIV are shown in **Figures 12 and 13**. Positivity rates were two times higher for African Americans than other race/ethnic groups, and rates of positivity were two times higher for men compared to women. Across risk groups, men who reported sex with men and using injection drugs (M/MS/IDU) and men who reported sex with men (M/MS) had positivity rates three and four times higher, respectively, than injection drug users (IDU) or men and women at risk through heterosexual sex (F/MS). The race/ethnic distribution of women testing HIV-positive is especially noteworthy: African-American women make up 23 percent of the HIV tests done for women, but 46 percent of the positive tests were among African American women.

## Accomplishments

- ❖ TDH staff assisted the City of Houston with adopting the revised scannable form for its contractors and assisted contractors with training and technical assistance in the use of the form (Note: the City of Houston receives separate funding for its HIV prevention efforts from TDH and is responsible for its own community planning process, data collection, and monitoring process).

<sup>2</sup> Most PCPE clients have multiple risks for HIV. Mode of exposure is a way of categorizing clients by the risk behavior that they report that is most likely to expose them to HIV. The modes of exposures are listed in order of risk of transmission of HIV, beginning with the riskiest. The modes are: 1) male to male sex with injection drug use (M/MSIDU), 2) male to male sex (without injection drug use) (M/MS), 3) injection drug use (without male to male sex) (IDU), 4) heterosexual sex (F/MS), 5) other tissue/blood exposures (e.g., occupational exposures, transplants), and 6) no indicated risk for HIV (NIR).

**Figure 12. Percentage of HIV Tests and Positive HIV Tests by Sex and Ethnicity**

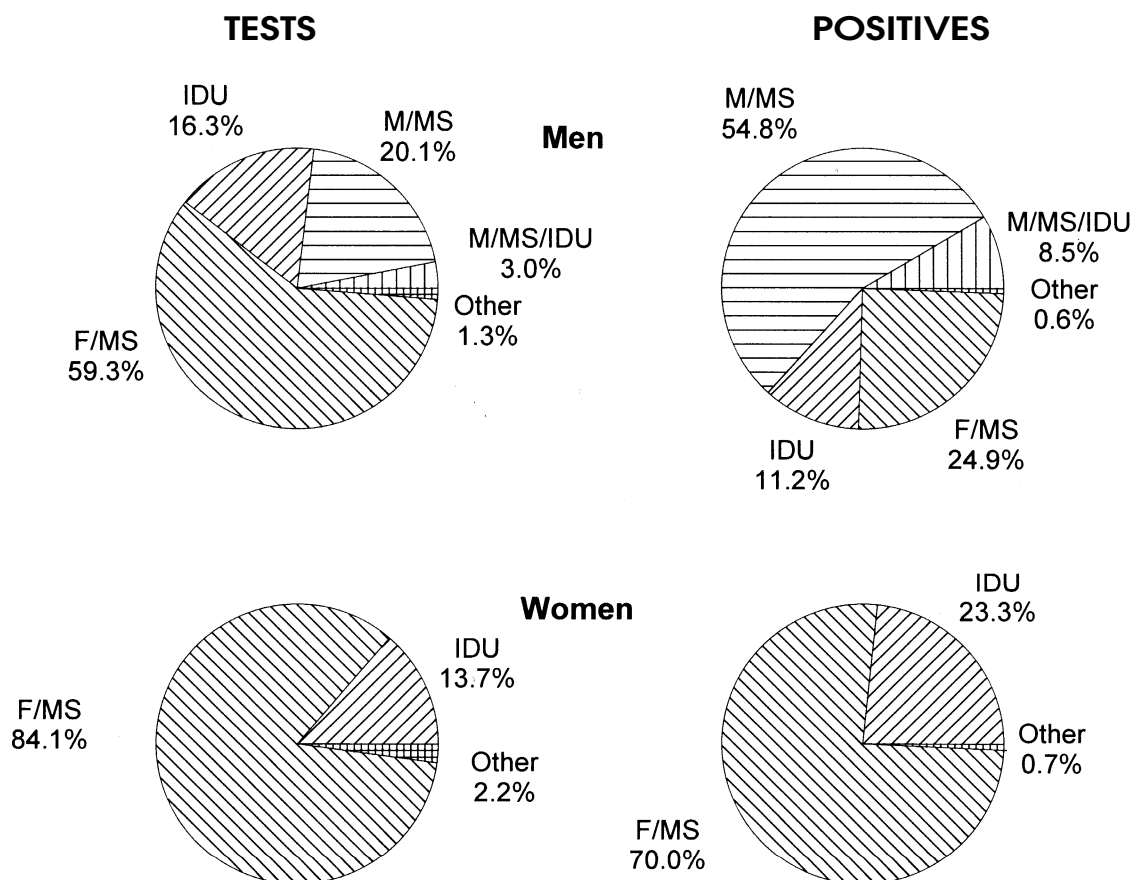


- ❖ PCPE contractors provided 118,715 HIV tests in 1999. Of these 1,215 were positive for HIV. This positivity rate, 1.0 positives per 100 tests, was similar to the rate in 1998.
- ❖ More than 60 percent of the HIV-positive clients counseled at PCPE contractor sites who returned for their test results were successfully referred to medical care and social services for their HIV infection.
- ❖ Information derived from the initial year of use of the scannable form has been used to develop a “risk profile.”

## **Future Plans**

- ❖ TDH will continue to provide guidance and technical assistance to ensure that PCPE contractors reach the targeted populations outlined in the regional prevention plans.

**Figure 13. Percentage of HIV Tests and Positive Tests by Sex and Mode of Exposure**



- ❖ TDH will continue to emphasize the importance of augmenting on-site, clinic-based counseling and testing services with PCPE services provided at non-traditional sites with the goal of making counseling and testing more accessible to target populations. Non-traditional sites refer to field testing that occurs in places where high-risk activities involving a targeted population takes place or where members of a targeted population congregate.
- ❖ In a further effort to expand accessibility, PCPE contractors are expected to continue using counselors who are peers of the targeted populations.
- ❖ TDH will continue to improve the process of linking individuals testing positive through PCPE with HIV services and secondary prevention.

## HIV SERVICES

The Texas HIV Services program was established in 1989 in response to *AIDS in Texas: Facing the Crisis*, the final report of the Texas Legislative Task Force on AIDS. In supporting basic treatment and health and social services to HIV-infected Texans, the Texas Legislature charged the HIV/STD Health Resources Division (Division) to:

- ❖ coordinate the use of local, federal and private HIV Services funds;
- ❖ encourage the provision of community-based HIV services;
- ❖ address needs not met by other funding sources;
- ❖ provide statewide distribution of HIV Services funds that reflect regional needs; and
- ❖ encourage cooperation among local HIV service providers (Health and Safety Code, Chapter 85, sec. 85.032).

Additionally, the reauthorized Ryan White CARE Act of 1996 mandated the development of a *Statewide Coordinated Statement of Need (SCSN)*, the purpose of which is to provide a mechanism to collaboratively identify and address significant HIV care issues. The mandate requires participation in the development of the SCSN by all the states CARE Act recipients. The SCSN is a multi-year, long-range project which will:

- ❖ ensure representation from consumers and all Ryan White (RW) grantees across all RW Titles, resulting in collaboration and coordination;
- ❖ include a strong emphasis on needs assessment activities;
- ❖ identify State systems and activities and services that are already in existence;
- ❖ look at how epidemiological data are currently being used at the local level;
- ❖ create a better network of local/State communication;
- ❖ facilitate capacity development of providers as it relates to HIV services; and
- ❖ provide opportunities to collaborate with peers and colleagues statewide.

## SERVICE DELIVERY

During 2000, the Bureau of HIV and STD Prevention, in compliance with both State and federal mandates, distributed over \$20.6 million in HIV services contracts throughout the State. To award HIV Services funds as extensively and equitably as possible, the Bureau divides the eleven Texas Public Health Regions into 26 HIV Service Delivery Areas (HSDAs). A local HIV CARE Consortium made up of public and private HIV service providers, community-based organizations, HIV-infected individuals and community leaders serves each HSDA. The Consortium determines the needs of its community and allows local providers to coordinate services. This ensures that a wide variety of medical and social services are available to the local HIV-infected population.

TDH contracts with an administrative agency to manage the TDH contract. The funds available to each HSDA are determined through a new funding formula based on three factors at the following weights:

- ❖ 50% Number of reported living cases of HIV and AIDS in the HSDA;
- ❖ 30% Number of unduplicated clients receiving at least one publicly-funded service in three non-consecutive, randomly selected months from July 1999 through June 2000;
- ❖ 20% Percent of the HSDA=s population that is eligible for Medicaid (indicates economic distress of a community and is highly correlated with poverty).

Basic HIV services supported by TDH contracts with local health departments and community-based organizations include: ambulatory/outpatient medical care, hospice care, case management services, insurance assistance program, dental care, nutrition services, medications, home health care, mental health therapy, substance abuse treatment/counseling, and support services such as direct emergency financial assistance, food bank, housing, and transportation.

Physical and mental health services enable HIV-infected persons to remain healthier and independent, extending the time they can care for themselves and others without support. HIV services reduce the need for expensive hospitalizations and more costly treatments by providing preventative services and less costly home-based care. Since many HIV/AIDS clients are economically devastated by the disease, many must rely on publicly funded care. Providing cost-effective HIV services benefits all Texas residents by reducing health care costs supported by taxpayers.

## Accomplishments

- ❖ On July 6-7, 2000, TDH sponsored its annual Ryan White meeting for representatives from Title I, II, III, IV, and Part F grantees. Attendees also included Title II consortia chairpersons and Title II planning council chairpersons. The meeting included sessions on a variety of topics, including needs assessment, HRSA and TDH policies, the Texas Medication Program, case management opportunities for HIV prevention activities, and HIV services funding formula.
- ❖ TDH began implementation of its plan to restructure the planning and administration of HIV services in Texas that will assist in making these activities more manageable both in the local community and at the state oversight level. External stakeholders were involved in recommending parameters and providing suggestions for the restructuring process. TDH will continue to work with local communities to implement the new structure throughout 2000 and beyond.
- ❖ The Texas Statewide Coordinated Statement of Need (SCSN) Project moved forward at a fast pace during 2000. The SCSN developed a *Guide to Conducting a Needs Assessment*. The *Guide* identifies and describes the components of a comprehensive needs assessment; recommends particular actions in planning needs assessment activities, collecting the appropriate information and data, analyzing the data collected, and using the findings through report preparation; and provides a glossary, both English and Spanish copies of a client survey instrument, and a resource inventory.

- ❖ Texas successfully implemented a revised allocation formula which uses living cases of HIV/AIDS, number of active clients, and proportion of the jurisdictions population eligible for Medicaid to allocate federal and State resources for medical and social support services for people with HIV infection.
- ❖ TDH released a Request for Proposals (RFP) on August 23, 2000, specifically targeted to reduce barriers and improve access to HIV health and social services for underserved and emerging populations. Underserved and emerging populations may be racial or ethnic minorities, women, youth, substance abusers, pregnant women, homeless, mentally ill, multi-diagnosed individuals, etc. TDH anticipates continuing funding projects under this RFP for a three-year period ending March 31, 2004.

## **Future Plans**

- ❖ TDH will reduce the number of Administrative Agencies from 26 to no more than twelve.
- ❖ In collaboration with Consortia and administrative agencies, the TDH will continue to expand and revise written policies and procedures for efficient Consortia and administrative agency operation.
- ❖ The TDH will continue to provide technical assistance to Consortia and administrative agencies to improve their working relationships and incorporate broad community input into their processes.

## **HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)**

The Housing Opportunities for Persons with AIDS (HOPWA) program provides emergency housing assistance and rental assistance to eligible persons with HIV/AIDS and their families. The primary objective of HOPWA is the provision of assistance to continue independent living for persons with HIV/AIDS in Texas and their families. In 2000, the TDH received \$2,245,000 in funds from the U.S. Department of Housing and Urban Development (HUD) for the HOPWA program. Twenty-five of the state's 26 HSDAs receive HOPWA funding through a contract with the administrative agency serving the HIV CARE Consortia located in those HSDAs. Each administrative agency serves as the project sponsor and either directly administers the HOPWA funds or contracts with another provider for delivery of these services.

## **Accomplishments**

- ❖ In 1999, the HOPWA program provided housing assistance to 2,248 persons with HIV/AIDS and their families.



- ❖ In previous years, the U.S. Department of Housing and Urban Development has cited the HOPWA program in its “best practices.”

## **Future Plans**

- ❖ TDH is in the process of developing guidance for sponsors to implement the following three additional HOPWA activities: (1) Project-based rental assistance which will provide the same services as tenant-based rental assistance, except that the project sponsor will contract with the landlord of a particular rental property instead of the tenant choosing their own rental property. (2) Resource Identification will allow the provision of technical assistance to local service organizations to establish, coordinate and develop housing assistance resources for eligible persons (including conducting preliminary research and making expenditures necessary to determine the feasibility of specific housing-related initiatives). (3) Operating Costs will allow HOPWA sponsors to use grant funds for operating costs for housing including maintenance, security, operation, insurance, utilities, furnishings, equipment, supplies, and other incidental costs.

## VI. STD PREVENTION AND SERVICES

Sexually transmitted diseases (STDs) are a major threat to the health of Texans. Young women and their children are especially at high risk for STDs and the resultant complications. Babies born to infected mothers are often the ones to suffer the most from STD infections. STDs such as syphilis and HIV are passed to the fetus through the mother's blood while she is carrying the child or at delivery. Others, such as gonorrhea, chlamydia and herpes, may be transmitted to the newborn at the time of delivery. STDs in children can lead to fetal death, retardation, crippling, blindness, deafness, pneumonia and low birth weight. STDs in women can lead to chronic debilitating pain, ectopic pregnancy, sterility, cancer and death. Adolescents are at higher risk for acquiring STDs for several reasons: a tendency to have multiple partners, to have unprotected sex, and to select partners at high risk. Adolescent women have a physiologically increased susceptibility to infection; furthermore, teenage women have steadily increased their number of premarital sexual encounters during the past two decades. At the same time, adolescents often encounter the most obstacles to seeking health care. STDs are a particularly significant health problem for economically disadvantaged minority populations.

**For every \$1 spent on early gonorrhea and chlamydia detection and treatment, \$12 in associated costs could be saved.<sup>3</sup>**

The goal of STD prevention and services is to prevent the spread of high priority STDs such as syphilis, HIV, chlamydia, and gonorrhea. The foundation of this effort is built on six primary components: community/individual behavior change; surveillance/data management; partner services/disease intervention; medical/laboratory services; leadership/program management; and training and professional development. Five of these components are discussed below; training and professional development activities are addressed in the Training and Public Education section of the report.

Dramatic changes in the health care industry in recent years have meant that health departments no longer serve as sole source providers of STD prevention and control services. The responsibility for STD service delivery has been increasingly spread among members of private health care systems, such as HMOs. The Bureau of HIV/STD Prevention undertakes activities to empower communities in the identification and meeting of these needs. STD program personnel around the state participate in HIV Community Planning Groups and collaborate with community based organizations to provide outreach, screening and treatment services to at-risk populations in non-traditional settings. Additionally, the Bureau developed an innovative media campaign targeting adolescents during 1999.

Health care providers and laboratories in Texas are required to report syphilis, gonorrhea, chlamy-

<sup>3</sup> Institute of Medicine. The Hidden Epidemic: Confronting Sexually Transmitted Diseases. Washington, DC: National Academy Press, 1997, p.7.

dia, chancroid, AIDS, and HIV infections. Surveillance, the collection and analysis of data about the occurrence of disease, is crucial to the success of any disease control effort.

Analyzing case reports provides information needed to plan appropriate prevention and control activities and predict disease trends. The Bureau uses the STD Management Information System (STD\*MIS), a CDC-developed computerized morbidity surveillance system. Both the TDH regional STD programs and local health department programs collect disease reports within their jurisdiction, and transmit the information to TDH. TDH monitors the extent of the statewide STD problem and changes in demographic and geographic distribution of cases. This information is used to prioritize problems, allocate program resources, and plan and direct activities to respond to changing conditions.

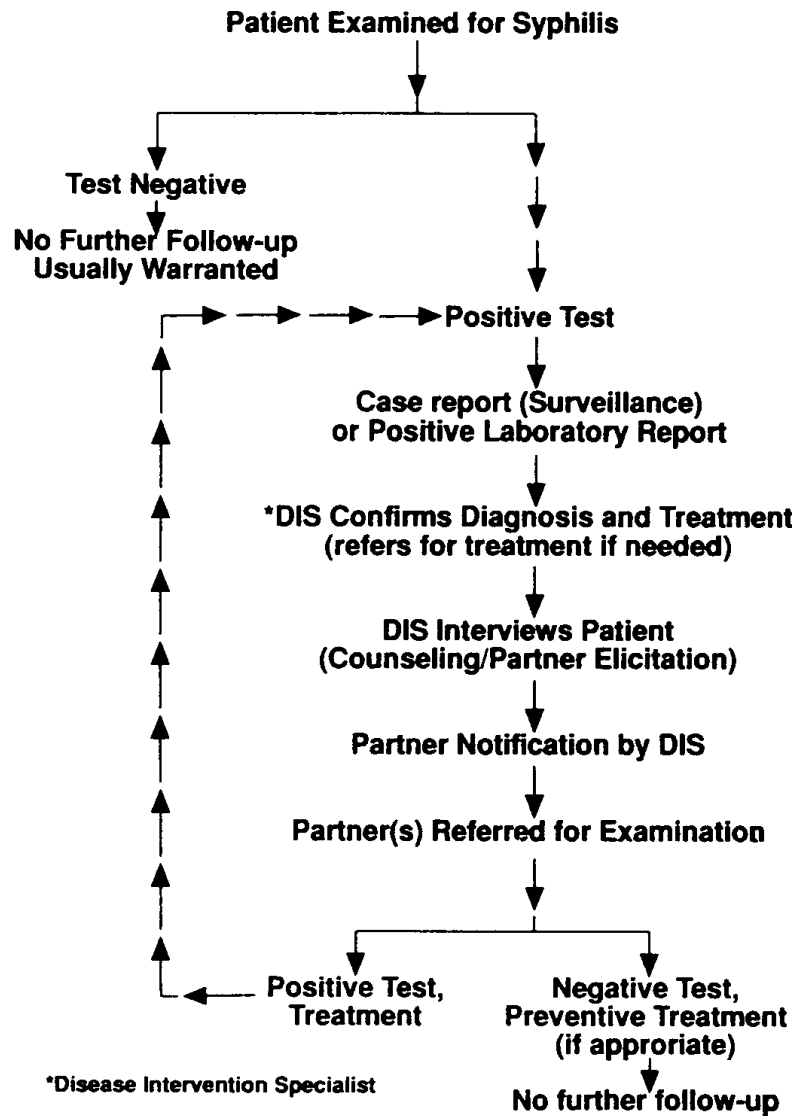
Highly trained DIS routinely perform syphilis and HIV counseling/interviewing, case management, and partner notification and service activities for individuals infected with these STDs. In certain locales where resources permit, they also perform targeted gonorrhea and chlamydia case finding. DIS also provide targeted prevention counseling to clients identified as high risk for STD. PCPE activities are routinely performed with early syphilis and HIV-infected individuals. PCPE is applied to both gonorrhea and chlamydia clients as resources allow.

The disease intervention process usually begins when a DIS receives a report of an infected or at-risk client. The DIS locates the person, refers him/her for examination and treatment, and counsels him/her on methods to reduce the risk of acquiring or transmitting STDs and HIV in the future. The DIS elicits the names, addresses, and other locating information of sex and/or needle sharing partners, and through field investigation, locates and refers these partners for examination, treatment and/or counseling. The cycle (see **Figure 14**) continues with the identification of each infected partner. When a contact is notified, they are not told who identified them as a potential contact. All disease intervention activities are completely confidential.

Through its medical and laboratory services, the Bureau purchases and distributes medicines for the treatment of priority STDs to regional and local health departments and other key providers through the Clinical Resource Division's Texas HIV Medication Program, which is highlighted later in this report. Laboratory services are provided for screening high risk clients for gonorrhea, chlamydia, HIV and syphilis through the state laboratory system. TDH purchases HIV/STD disease intervention services from regional and local health departments and funds local physicians to examine and treat STD patients exposed to syphilis, chlamydia and gonorrhea when no publicly-funded facilities are available. Similarly, TDH funds client services delivered by the Baylor College of Medicine Teen Clinic in Houston. Through a contract, TDH supports STD examinations and treatment at three clinics. These teen clinics serve high risk adolescent females who otherwise would not seek health care. This partnership ensures that teenagers in Houston have access to needed STD services.

TDH's leadership and management keep the program focused on maintaining high standards for STD contractors around the state and acquiring the technical skills and knowledge to remain proactive in a changing health care environment. TDH has developed guidelines and established standards for STD program performance. Regional and local STD programs provide detailed reports on morbidity and progress on objectives semi-annually.

Figure 14. The Disease Intervention Process



## Accomplishments

- ❖ Prevention activities provided by STD programs resulted in an estimated \$48,391,000 savings in medical costs related to STDs and \$21,336,000 in savings related to HIV in 1999.<sup>4</sup>
- ❖ During 1999, DIS interviewed and managed 1,487 reported syphilis cases; as a result of disease intervention activities among high risk associated individuals (i.e. partners), 404 new cases of syphilis were identified and treated, and 799 persons were preventively treated for syphilis.
- ❖ Texas' implementation of the CDC-funded Syphilis Elimination Project took off in 2000, with the hiring of a statewide coordinator and local coordinators for the state's two high morbidity areas (HMAs), Dallas and Harris Counties. Community coalitions made up of public and private organizations representative of and serving affected communities were also formed in the two HMAs.
- ❖ As part of the Syphilis Elimination Project, TDH, as well as local STD Programs, developed and implemented Rapid Response Plans to facilitate containment of unusual increases in syphilis morbidity.
- ❖ DIS provided PCPE to 1,167 HIV-positive individuals in 1999, resulting in the location, counseling, and testing of 1,665 HIV sex/needle sharing partners. DIS successfully referred 1,011 (86.6 percent) of the HIV-positive individuals to early intervention services.<sup>5</sup>
- ❖ During 1999, the gonorrhea screening program tested 338,181 persons, identified 15,611 positives (4.6 percent) and confirmed treatment on 14,077 (90.2 percent). The chlamydia screening program tested 337,832 persons, identified 26,145 positives (7.7 percent) and confirmed treatment on 24,429 (93.4 percent).
- ❖ Through, the CDC-funded Infertility Prevention Project, the Bureau of HIV and STD Prevention collaborated with the TDH Bureau of Laboratories, the TDH Family Planning Division and its Planned Parenthood affiliates to provide STD screening and medication to their clients.
- ❖ In 2000, all STD programs around the state participated in collaborative activities with public and private organizations to increase awareness of STDs. In Houston, the STD Program and its CBO partners held an African American Women's Summit that resulted in the creation of a new group called "Sisters on Sundays" (SOS), which will bring together African American women from faith communities to increase STD and HIV/AIDS awareness in their communities. STD personnel in PHR 1 were especially active, giving more than 30 presentations and screening events to adolescents in venues that included juvenile justice centers,

<sup>4</sup> Revised from previous report.

<sup>5</sup> Revised from previous report.

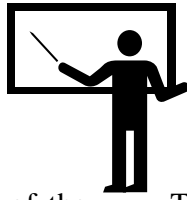
alternative education programs, mental health programs, orphanages and charter schools, as well as public elementary, junior high and high schools.

- ❖ TDH has been active in promoting the use of electronic laboratory reporting to accelerate case reporting and enhance the disease intervention process. As of 2000, ten high volume private laboratories around the state utilize electronic laboratory reporting, making electronic reports available daily to local health departments in Dallas, El Paso, Fort Worth, Houston, San Antonio, Waco, Wichita Falls and TDH Public Health Regions 1, 7, and 8. This cutting edge innovation will be spotlighted at the 2000 National STD Conference.
- ❖ A draft needs assessment tool, which includes STD information, was submitted to HIV Community Planning Groups for use in the next planning cycle to determine interventions to be funded with CDC-provided HIV Prevention funds.
- ❖ A STD Client Satisfaction Survey was piloted in three high volume STD clinics, which when complete will enhance TDH's quality assurance system.
- ❖ Work was begun in 2000 in conjunction with the City of Houston to conduct an assessment of STD screening practices among selected managed care organizations in four geographical areas in the state, to determine gaps in STD screening, counseling and treatment of partners among private providers. The survey will be conducted by the University of Texas Office of Survey Research.
- ❖ TDH has begun a routine match of HIV morbidity information entered into the STD\*MIS database with HIV morbidity reported through the HARS system. Potential new cases identified through the matching process are then referred to DIS for investigation.
- ❖ TDH's Epidemiologic Monitoring Branch applied for and received funding from the CDC for two new grants: *Monitoring STDs, Tuberculosis and Risk Behaviors in Men Who Have Sex With Men* and *Reinventing Surveillance Systems for Communicable Disease Prevention*. Both grants were competitive nationally. The former will assist the Montrose Clinic of Houston in improving its client tracking system, and the latter will enhance the ability of TDH to perform spatial analysis of co-morbidity among STDs, HIV, TB and other infectious diseases, as well as maternal and infant mortality.
- ❖ A Partner Services Summit was held in February 2000 to bring together STD program staff and community based organizations from around the state for the purpose of encouraging them to enter into cooperative agreements to enhance prevention and control activities directed at partners of HIV and STD positive clients.
- ❖ As an incentive for the quality of its CDC STD grant application, in 2000 TDH was awarded additional funding to begin limited testing of males for chlamydia in selected sites.

## Future Plans

- ❖ Local and regional STD programs will continue to collaborate with public and private organizations such as jails, youth detention centers, homeless shelters, and neighborhood health facilities to provide outreach and screening for populations at risk for acquiring and transmitting STDs.
- ❖ Collaborative activities for 2001 will include continued exploration of additional areas for STD and HIV coordination to best utilize program resources and improve or expand delivery of services, especially regarding women offered STD screening outside of STD clinics.
- ❖ TDH will continue to urge high volume laboratories around the state to institute electronic laboratory reporting, including the TDH laboratory, which serves many local and regional STD programs.
- ❖ TDH and the state's two syphilis HMAs will develop and implement syphilis elimination plans.
- ❖ TDH will study the feasibility of adopting amplified DNA technologies for chlamydia and gonorrhea testing, which is expected to increase the detection of morbidity of these diseases in the short term, and lead eventually to enhanced disease prevention and intervention.
- ❖ Selected local STD programs and private family planning clinics from around the state will participate in a Specimen Adequacy Study as part of the ongoing Infertility Prevention Project.
- ❖ Funds have been identified for adding an STD clinician consultant to Bureau staff to enhance technical assistance, quality assurance and monitoring of local and regional STD programs.
- ❖ TDH will implement a Male Chlamydia Project to screen males at selected sites and provide information to local funding authorities on male chlamydia positivity rates within those jurisdictions.
- ❖ New projects for *Monitoring Prevalence of STD, TB and Risk Behaviors Among Men Who Have Sex With Men* and *Reinventing Surveillance Systems for Communicable Disease Prevention* will be implemented.

## VII. TRAINING AND PUBLIC EDUCATION



The overall mission of the Training and Public Education Branch (TPEB) is to develop and provide accurate, specialized HIV/STD information and training to diverse audiences using effective, appropriate methods of communication and education. TPEB staff plan, develop, conduct, and evaluate all HIV/STD training, public information, and education initiatives for the Texas Department of Health (TDH), other State agencies, local health departments, and community based organizations involved in HIV and STD activities. Program-specific educational materials and guidelines are developed for use in disease prevention activities. TPEB staff facilitate the delivery of HIV/STD training and public education by:

- ❖ Providing direct training for courses such as the four-day HIV/STD/Viral Hepatitis *Prevention Counseling/Partner Elicitation* (PCPE) course, the 10-day *Introduction to Sexually Transmitted Disease Intervention* (ISTDI) course, and the one-day cultural competency course entitled, *The Never Ending Journey*.
- ❖ Providing “Train the Trainer” courses in which TPEB instructors teach other State agency and community-based organization staff to present TDH-approved instructional packages.
- ❖ Developing and providing customized training to individual programs to address specific needs.
- ❖ Developing, updating, and disseminating HIV/STD/Viral Hepatitis guidelines, curricula, literature, audiovisuals, and other educational materials.
- ❖ Maintaining the Texas PCPE Registry of all counselors who have successfully completed the courses required by TDH in order to deliver PCPE services in Texas. The Registry includes HIV PCPE counselors trained by TDH, Texas Commission on Alcohol and Drug Abuse (TCADA) and Texas Department of Mental Health and Mental Retardation (TDMHMR) via an interagency Memorandum of Understanding (MOU). TPEB staff provide technical assistance to HIV prevention contractors and STD programs in evaluating their training needs and ensuring those needs are met. TPEB continues to receive out-of-state participants referred by the Centers for Disease Control and Prevention (CDC) for STD courses.
- ❖ Staffing the Texas HIV/STD InfoLine, a toll-free, bilingual information source offering basic information on HIV/AIDS/STDs/Hepatitis referrals, including recorded information or the option to speak to HIV/STD health professionals.



- ❖ Conducting public information activities, including media campaigns, press releases, news features, announcements and general public information requests.
- ❖ Conducting public awareness events, including National Condom Week, STD Awareness Month, National HIV Testing Day, AIDS Awareness Month, World AIDS Day, and health fairs.
- ❖ Developing, purchasing and disseminating HIV/STD educational materials, including pamphlets, brochures, posters, videos and related materials to HIV/STD health professionals and the general public.
- ❖ Conducting the biennial Texas HIV/STD Conference, a major training event for TDH contractors, including more than 90 sessions with approximately 1,000 participants, offering professional continuing education for physicians, nurses, social workers, licensed professional counselors, certified health educators, and substance abuse counselors.
- ❖ Conducting staff development and distance learning events, including satellite video teleconferences, self study courses, STD Lunchtime Learning Series, and New Employee Orientation Programs.
- ❖ Writing and distributing the *Texas HIV/STD Update*, the HIV/STD news bulletin of TDH, as well as an electronic version of the bulletin, the E-Update, for more urgent or timely information sent to an e-mail mailing list.
- ❖ Developing, updating, and distributing the Texas HIV/STD Community Resource Directory, including hard copy and online versions, which include a listing of Texas HIV/STD services providers, State agencies, helpful phone numbers, and Internet resources.
- ❖ Developing, updating, and distributing the Texas Resource Guide for HIV/STD Education, a resource manual for HIV/STD health education professionals in Texas.
- ❖ Conducting Program Materials Review Panel meetings, an expert panel for review of HIV/AIDS/STD educational materials identified for use within specific target populations as well as the general public.
- ❖ Maintaining a resource library of guidelines, manuals, and standards.
- ❖ Maintaining the training, public information and education sections of the Bureau of HIV & STD Prevention Web Site, including the online version of the Community Resource Directory, the biennial conference pages, InfoLine, newsletter, calendar, educational resources, and handling all e-mails sent to the web site from the general public.

## Accomplishments

- ❖ TPEB was notified in April by the CDC of the award for the Prevention Training Center (PTC) Partner Services and Support Services Training (Part III) grant. This national grant will allow TDH, in conjunction with the Dallas County Health and Human Services, to provide quality training for STD/HIV partner and support services, including program management, surveillance and data management, and outbreak response planning and evaluation for the following states: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Arkansas, Louisiana, New Mexico, Oklahoma and Texas. TPEB conducted five ISTDIs in its first six months of operation. TPEB staff is conducting a DIS ISTDI needs assessment of the 13 states.
- ❖ The National Public Health Information Coalition awarded a prestigious Bronze Award to TPEB for Excellence in Public Health Communication for their 1999 STD Media Campaign. The pilot campaign used TV, radio and billboards to bring STD awareness and prevention messages to African American adolescent girls in the Tyler/Longview market. The Bureau expects to roll the campaign out in another Texas market in 2001.
- ❖ TPEB staff facilitated eight video teleconferences during 2000. TPEB's Video Teleconference Program is designed to provide health professionals with ongoing, up-to-date information on prevention, intervention, treatment, and related news on HIV, AIDS, STDs, and other infectious diseases. These are live events in which participants can interact with video teleconference participants, speakers, and panel members from across the nation.
- ❖ TPEB continued its "STD Lunchtime Learning Series" during 2000. The series is designed to provide HIV/AIDS/STD health professionals with ongoing, updated information on the latest advances in STD prevention, intervention, treatment, and related news.
- ❖ TPEB staff collaborated with the Infectious Disease Epidemiology and Surveillance Division (IDEAS) on developing hepatitis brochures and scripts. Hepatitis A, B and C scripts will be incorporated into the Texas HIV/STD InfoLine automated information service, allowing Texas callers to access educational tapes on these diseases. These specialized scripts will replace the current hepatitis InfoLine script that covers all types of Hepatitis in a more generic fashion.
- ❖ TPEB staff completed putting the *Texas HIV/STD Community Resource Directory* on-line and it can be found at [www.tdh.state.tx.us/hivstd/commsvcs](http://www.tdh.state.tx.us/hivstd/commsvcs). The on-line CRD is a convenient way to find HIV/STD services providers in the State of Texas, as well as TDH regional contacts for HIV/STD, local health departments, State agency resources, and much more.
- ❖ TPEB staff developed a new course entitled *Hepatitis in the New Millennium*, which was held November 10 at the University of Texas Southwestern Medical Center, Comprehensive Center for Liver Research and Treatment in Dallas. Topics covered include virology and testing, pathology, prevention, evaluation of the HCV patient, and planning a public health program for HCV.

- ❖ TPEB staff provided training for the CDC Options research project October. Conducted by the University of California, San Francisco. Options is an epidemiological and clinical intervention study on persons with recent HIV infection.
- ❖ TPEB continued its involvement in the Hepatitis C Virus initiative and will work with the Research and Program Evaluation Branch Manager on revision of the Counseling and Testing System data collection forms to include Hepatitis C Virus testing.
- ❖ TPEB staff presented a peer counseling program for women incarcerated at Gatesville Women's Prison in September. The staff teamed up with AIDS Foundation Houston (AFH) to develop this pilot program. Additional training is planned and will be developed and refined based on the response to this pilot.
- ❖ TPEB revised the four-day PCPE curriculum and conducted training of trainer courses for all state instructors. The most notable changes in curriculum include the addition of an entire module devoted to viral hepatitis and a revision of partner elicitation methods in the Pre-Course. A PDF version of the updated and revised Pre-Course is available on-line at [www.tdh.state.tx.us/hivstd/educate/training.htm](http://www.tdh.state.tx.us/hivstd/educate/training.htm).
- ❖ TPEB staff collaborated with the Center for Health Training to co-sponsor the 2000 HIV/STD/Family Planning Nurses Conference.

## VIII. HIV/STD CLINICAL RESOURCES

The Clinical Services Section was officially reorganized on April 1, 2000, to become the HIV/STD Clinical Resources Division. The Clinical Resources Division (CRD) is composed of three programs: the Texas HIV Medication Program (THMP), the Clinical/Case Management and Administrative Compliance Program and the Early Intervention Program (EIP). The CRD is also responsible for administering the HIV/AIDS Interagency Coordinating Council.

The primary mission of the CRD is to enhance the lives of individuals with HIV disease by providing life-sustaining medications, and ensuring quality clinical and case management services are available and accessible.

### TEXAS HIV MEDICATION PROGRAM (THMP)



The THMP is responsible for the purchase and distribution of medications for the treatment of HIV disease and other sexually transmitted diseases. The Texas HIV Medication Program also provides medications for the treatment of opportunistic infections for people with HIV disease. Medications for the treatment of HIV disease are provided to clients through a network of pharmacies statewide. The HIV Medication Advisory Committee is also administered by the THMP.

THMP distributed over \$42.9 million in antiretroviral drugs and other prophylactic medications in FY 2000, a 19.6% increase over FY 1999 levels. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. The Medication Reimbursement Initiative paid deductibles and co-insurance payments in the amount of \$37,867. THMP also distributed \$1,015,500 in STD medications and related supplies to 52 sites statewide in 2000.

THMP provides medications to HIV-infected individuals who qualify for enrollment in the program across the State. Working through 238 participating Texas pharmacies, the program purchases and distributes over \$42.9 million annually in antiretroviral drugs and other prophylactic medications.

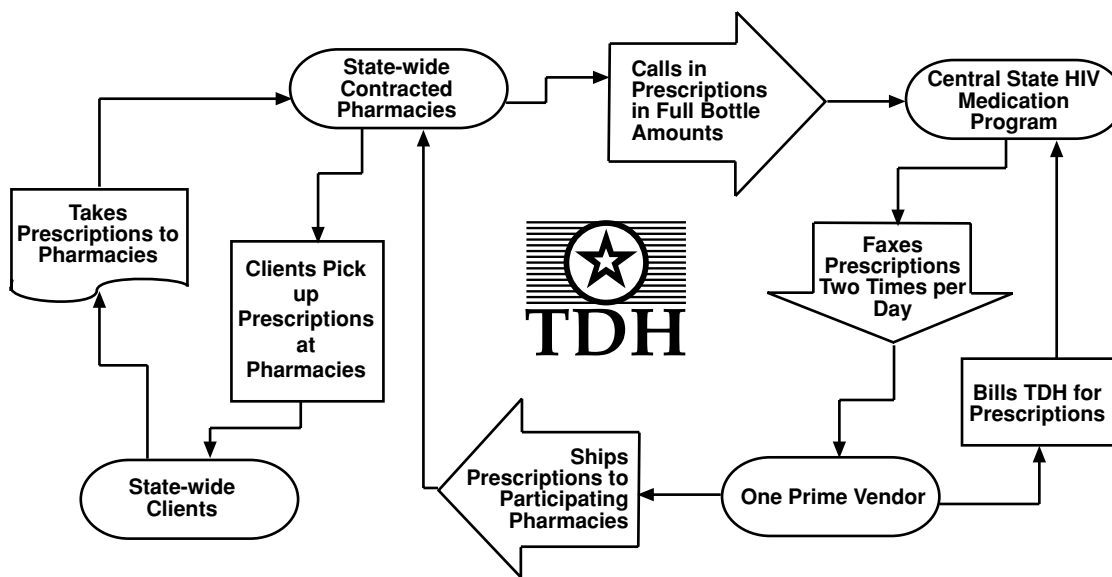
Since its inception in late 1987, THMP has provided HIV medications to over 30,000 Texans. Currently, the program receives and approves more than 176,000 medication orders each year. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. **Figure 15** shows how the program operates to ensure that qualified individuals anywhere in Texas have access to needed medications in a simple and timely manner.

The THMP develops and maintains confidential data files that provide valuable statistical information regarding medication usage to the Surveillance section of the HIV/STD Epidemiology Division, service providers, and lawmakers while preserving client confidentiality. THMP also collaborates with the Medicaid Vendor Drug Program to ensure optimum service delivery and avoid duplication of services. In order to maximize its medication purchasing flexibility and utilization of funds, the THMP developed and maintains its own accounting systems.

In addition to its regular services, the THMP operates the Medication Reimbursement Initiative (MRI). This program, formerly known as the Pilot Insurance Program, is operating in its sixth year of existence. The MRI program pays the deductibles and co-insurance payments required by the insurance companies of approved clients, who then receive medications directly at their homes. The MRI program affords eligible HIV-infected persons the opportunity to use the prescription benefits on their insurance policies while keeping the State support costs to a minimum by utilizing private sector funds. Persons with insurance benefits that provide for prescription medications would otherwise be disqualified from receiving regular THMP services.

THMP has contracted with Priority Pharmacy in San Diego, California to provide MRI medications. Priority Pharmacy has specialized in home delivery pharmacy services to HIV patients since 1987. To apply for MRI services, eligible applicants submit a completed regular Medication Program application and a completed client profile sheet with all the correct insurance information. Priority Pharmacy then verifies the applicant's prescription medication insurance benefits from this completed client profile. Priority Pharmacy also agrees to deliver the medications to each approved client by overnight mail at no cost to the approved applicant or TDH. They also provide a toll-free number to all approved clients, their physicians, and TDH for all communications relating to the approved applicant, their prescriptions, and access to an on-staff social worker.

**Figure 15. The Texas HIV Medication Program**



## **STD MEDICATION**

The THMP distributed \$1,015,500 in STD medications, needles, and protective needle adapters to 52 sites statewide in FY 2000. These sites include Public Health Region Offices, county health departments, and local health departments. These sites then deliver treatment directly to STD clients or supply the medications to the community providers who treat the clients.

## **CLINICAL, CASE MANAGEMENT AND ADMINISTRATIVE COMPLIANCE PROGRAM**

This Program is responsible for conducting quality assurance reviews of State and federally funded grantees that provide clinical and/or case management services to individuals with HIV disease. To accomplish this, THMP staff conduct annual site reviews, provide technical assistance by telephone and on-site as needed, develop and distribute minimum clinical and case management standards and conduct investigations into allegations of client abuse and neglect. The Program also provides consultation regarding HIV disease and other STD's to health care professionals and the general public as requested.

## **EARLY INTERVENTION PROGRAM (EIP)**

Early intervention is a strategy of service delivery to persons with HIV that focuses on delaying the onset of life-threatening symptoms and diseases. Services provided through the EIP include clinical care, health maintenance activities, prevention of acute and chronic illness, and support services. The EIP in Texas was initiated in 1992 to provide health care and psychosocial services to Texans who have tested positive for HIV. The intent of initial funding was to provide services that would delay the onset of AIDS. Recent advances in medical and pharmacological protocols have shown that early intervention effectively reduces the levels of virus in the body. Since its inception, the Texas EIP has evolved from a program focused only on HIV infected people, to a program that aims to promote and maintain optimum health at all stages of the disease, including AIDS. Currently there are eight EIP projects funded Statewide. These projects aim to:

- ❖ Establish and provide necessary clinical, clinical case management and psychosocial supportive services to individuals with HIV disease which prevent illness and promote optimum health;
- ❖ Provide these services in areas where such services do not exist;
- ❖ Provide access to early intervention activities and strategies to persons with HIV disease;
- ❖ Locate and contact individuals with HIV disease, their partners and/or children (if client is an adult/adolescent) or parents/guardians (if client is a child) as early as possible in the course of the infection so that services may be offered;
- ❖ Delay disease progression through timely initiation of proven preventive services and health maintenance activities;
- ❖ Prevent or reduce behaviors that result in the spread of the virus; and
- ❖ Increase life expectancy and improve the quality of life.

# **HIV/AIDS INTERAGENCY COORDINATING COUNCIL**

The HIV/AIDS Interagency Coordinating Council was established by the Legislature to facilitate communication between agencies and associations involved in providing HIV/AIDS services to individuals, families and communities. The Council is also responsible for coordination of agency programs relating to the prevention of HIV/AIDS and the provision of services to people infected with HIV or who have AIDS, and for submitting an annual report to the Governor with recommendations and plans regarding coordinated activities to address issues and problems affecting this population.

The Council is composed of one representative appointed from each of the following:

- ❖ Texas Health and Human Services Commission
- ❖ Texas Department of Health
- ❖ Texas Department of Mental Health and Mental Retardation
- ❖ Texas Department of Human Services
- ❖ Texas Commission on Alcohol and Drug Abuse
- ❖ Texas Rehabilitation Commission
- ❖ Texas Youth Commission
- ❖ Texas Department of Criminal Justice
- ❖ Texas Commission for the Blind
- ❖ Texas Commission for the Deaf and Hearing Impaired/Hard of Hearing
- ❖ Texas Department of Protective and Regulatory Services
- ❖ Texas Education Agency
- ❖ Texas State Board of Medical Examiners
- ❖ Board of Nurse Examiners for the State of Texas
- ❖ Board of Vocational Nurse Examiners
- ❖ State Board of Dental Examiners
- ❖ Texas Juvenile Probation Commission

## **Accomplishments**

- ❖ Coordinated development of Blood Borne Pathogen Control rules that were adopted by the TDH Board of Health. Activities included chairing a stakeholder workgroup charged with implementing House Bill 2085, and guiding the draft rules through the TDH rule-making process. Beverly Ray, RN, Nurse Consultant who coordinated the development and adoption of the rules, was a speaker at two workshops provided by the Texas Hospital Association to their members regarding the BBP rules.
- ❖ CRD undertook major revisions to the proposed Medicaid 1115 Waiver affecting HIV positive clients in the counties of Harris and Galveston counties, including expansion of clinical services to conform with current standards of clinical care related to medications, laboratory testing, preventive services and other current medical practices. CRD also worked with Epi-

demography Division staff to plan for reallocation of Texas HIV Medication Program funds that would be affected by approval of the Waiver.

- ❖ CRD continues to work with contractors, clinical practitioners and agencies and the general public to report suspected incidences of abuse or neglect of clients, and possible child abuse. Examples of these activities include CRD filing of a report with Child Protective Services (CPS) of possible sexual abuse of child/children based upon telephone call from a member of the general public (caller was reportedly the grandmother of the alleged victim(s); follow-up monitoring of the CPS response indicated that the report resulted in an immediate investigation of the situation.
- ❖ CRD has participated extensively in the current restructuring of client services and prevention efforts underway within TDH. CRD has developed criteria for selection of administrative agencies with regard to their selection of clinical and social services subcontractors, communicated the restructure process as it affects direct client clinical services to current contractors, and conducted site reviews to applicant agencies to evaluate their capacity to develop and implement health and social services in communities across the state.
- ❖ Routine monitoring visits to evaluate the quality of clinical, clinical case management and social case management services were completed by CRD at twenty-one statewide agencies. Extensive technical assistance to improve client services was provided at several of the agencies that had a past site visit finding of one or more deficiencies in meeting CRD standards.
- ❖ CRD worked with Health Resources Division and statewide contractors to identify clinics where expanded screening and treatment for sexually transmitted diseases in populations with HIV disease can occur.
- ❖ CRD provided clinical technical assistance to Regional staff, private practitioners, other health care providers and agencies, and the general public on topics including screening, diagnosis, and management of STDs.
- ❖ CRD, through THMP staff, purchased over 26,600 doses of Hepatitis B Virus (HBV) vaccine that is being distributed to contracted HIV clinics and clinical practitioners statewide for use in preventing HBV infection in HIV positive clients who are at risk for this disease.
- ❖ Initiated development of TDH protocol and physician standing delegation orders for Post-exposure Management of Occupational Exposure. Upon completion, this protocol will be distributed to TDH regional offices and sub-offices to allow proper clinical management of occupational exposure to HIV and HBV.
- ❖ CRD, through THMP staff, purchased medications that are to be used to prevent HIV infection of TDH staff when an employee is exposed to HIV as part of his/her work-related duties. These medications are being dispensed by the TDH Pharmacy, along with the post-exposure protocol mentioned above, to TDH regional offices and sub-offices for their use.



- ❖ THMP approved 176,152 medication orders dispensed through participating pharmacies to 10,041 individual clients.
- ❖ THMP has created an informational pamphlet detailing program services for statewide distribution. A copy of the brochure was included in a mass mailing to 19,000 Texas physicians, along with information on how to access the latest treatment guidelines for the use of antiretroviral agents in HIV-infected patients. Mailouts including the brochure were also sent to over 600 contract sites, local health departments and regional offices. THMP's brochure has also been translated into Spanish and is currently being prepared for printing and eventual statewide distribution.
- ❖ For Fiscal Year 2000, THMP paid MRI deductibles and co-insurance payments in the amount of \$37,867. The MRI program served a total number of 35 approved applicants in Fiscal Year 2000.
- ❖ In FY 2000, 42 clients were served a total of 943 prescriptions, at a cost of \$243,323 through the HOPE program.
- ❖ THMP has begun implementing outreach efforts to under served and hard-to-reach populations within the state. Presentations and exhibit booths were utilized at minority health conferences/symposiums and the statewide Ryan White "All Title" conference in order to increase awareness of the Medication Program.

**Table 4. HIV Medication Allocations by Region Fiscal Year 2000**

Region	Number of Clients Served	Amount Spent
1	203	\$791,875.41
2	131	\$499,847.97
3	2,645	\$10,790,280.64
4	382	\$1,595,230.56
5	284	\$945,795.06
6	3,142	\$13,579,998.67
7	1,166	\$4,908,747.58
8	1,056	\$4,772,440.65
9	127	\$597,823.28
10	415	\$2,105,202.20
11	490	\$2,321,257.60
<b>TOTAL</b>	10,041	\$42,908,499.62

- ❖ Twenty-nine pharmacies joined the statewide network, providing greater convenience for clients and reducing client loads at individual pharmacies.
- ❖ THMP developed and implemented the Medications Plus Program (MPP), which allows contractors that designate Ryan White Title II, State Services, or Early Intervention funds to purchase drugs through the Medication Program for their clients. The medications purchased through the MPP are paid for through contractor accounts set up by TDH, which allows the participating contractors to take advantage of the Public Health Service pricing on all medications ordered through this program. Contractors participating in the MPP must designate funds to purchase drugs through their existing TDH contracts and work through pharmacies already participating in the Medication Program.
- ❖ THMP staff continued implementation of the new statewide medication distribution and inventory control systems. The new system reduces the number of direct shipment sites statewide and centralizes medication inventory control in the local health departments and regional offices. This system ties STD morbidity to actual medication allotment in an effort to encourage timelier and more accurate reporting of STDs statewide. This relationship is also intended to help the program set realistic stock levels of STD medications for each of its shipment sites, rather than relying on less exact estimates.

## **Future Plans**

- ❖ In order to improve access to high quality clinical and social services in communities across Texas, the Nurse Consultants within the CRD will begin providing consultation and technical assistance to Community Planning Coalitions and HIV CARE Consortia charged with the responsibility for conducting and analyzing needs assessments for prevention and services in their respective communities. The registered nurses will assist in interpreting the data collected in these needs assessments in order to locate appropriate health care services/providers to meet the client's needs. They will also assist the Planning Groups in developing health care service delivery systems where these do not currently exist.
- ❖ The CRD will hire a registered nurse with experience in all sexually transmitted diseases to monitor STD clinical providers, plan and develop STD clinical delivery systems across the state, and related duties. The goal of this position is to improve the quality of STD screening and clinical services by TDH contractors and others in Texas.
- ❖ CRD will continue efforts to improve linkages to clinical care and medications for minority populations, with special emphasis on people with HIV who are being released for prisons/jails and from substance abuse treatment centers. CRD hopes to fund a clinical position to work with TDCJ and substance abuse treatment centers to establish/improve these critical linkages.

- ❖ CRD will update the current web site to improve access to information by contractors on monitoring activities, and direct access to current clinical information related to HIV and STDs by clinical practitioners and others.
- ❖ The HIV/AIDS Coordinating Council will consider expanding its focus to include activities related to the expanding Hepatitis C virus epidemic. NOTE: This is dependent on legislative direction.
- ❖ CRD will undertake a major revision of the standards by which contractor agencies for clinical and social services are monitored. This effort is directed at ensuring that standards are current, and also to reduce the duplication of effort required by agencies that are funded by different sources that have conflicting or confusing expectations. Ultimately, the standards should help ensure that clients receive adequate and appropriate services, and that funds to purchase these services are used in an effective manner.
- ❖ The current standard of care for treatment of HIV disease recommends that patients start on antiretroviral therapy with a combination of drugs earlier in the disease in order to preserve immune function. Using epidemiological research, THMP continues to study utilization trends and track monthly expenditures in order to accurately predict the program's growth patterns. THMP will continue to enlist the aid of an actuary service to work in conjunction with a Bureau epidemiologist in order to refine their cost and utilization projections.
- ❖ THMP will continue working to increase public awareness of its existence and outreach to potential clients statewide, with an emphasis on under served and hard-to-reach client populations. Whenever possible, staff members will either attend or set up a display at applicable health fairs, conferences and symposiums to share information and distribute THMP brochures, applications and guidelines.
- ❖ THMP will also proceed with streamlining the entire program's daily operations by implementing a totally revamped software program, currently in the final stages of development, that will improve turnaround times for processing client applications and prescription orders, thus making the program more efficient and user-friendly. In-house user acceptance testing for the new software program is scheduled to begin in December, 2000, with a targeted date of actual implementation set for late February, 2001.
- ❖ THMP will continue the new statewide distribution and inventory control system for all STD related medications. Pending available funding, the program will provide enough medication to treat a case and two contacts each for gonorrhea, chlamydia, syphilis, and pelvic inflammatory disease.

# IX. APPENDIX

## Texas AIDS Surveillance Report

Reported AIDS Cases January - December 1999

Residence County	Reported AIDS Cases				Reported HIV Cases	
	Cumulative Reported Cases	Cumulative Deaths	Jan-Dec 1998 Cases	Jan-Dec 1999 Cases	Cumulative Reported Cases 1999	Jan-Dec 1999 Cases
Region 1	718	444	74	72	51	51
Lubbock Co.	288	165	29	40	39	39
Potter/Randall Co.	303	196	34	23	9	9
Other	127	83	11	9	3	3
Region 2	465	239	29	34	32	32
Taylor Co.	135	74	7	9	8	6
Wichita Co.	177	86	8	13	15	15
Other	153	79	14	12	11	11
Region 3	15,128	8,412	944	759	743	743
Dallas Co.	10,956	6,173	617	536	551	551
Denton Co.	358	194	25	20	18	18
Tarrant Co.	2,949	1,615	210	132	127	127
Other	865	430	92	71	47	47
Region 4/5 N	1,263	669	120	153	124	124
Angelina Co.	64	37	4	11	9	9
Bowie Co.	121	71	13	8	12	12
Gregg Co.	165	73	25	18	12	12
Smith Co.	203	105	20	18	18	18
Other	710	383	58	98	73	73
Region 6/5 S	20,243	11,833	1,838	772	1,009	1,009
Galveston Co.	649	389	49	20	11	11
Harris Co.	17,823	10,435	1,605	680	918	918
Jefferson Co.	541	285	46	20	31	31
Montgomery Co.	252	149	33	11	4	4
Other	978	575	105	41	45	45
Region 7	4,645	2,602	381	361	186	186
Bell Co.	229	116	19	20	11	11
Brazos Co.	148	91	8	17	12	12
McLennan Co.	275	154	32	14	24	24
Travis Co.	3,407	1,933	265	249	116	116
Other	586	308	57	61	23	23
Region 8	4,112	2,216	271	231	174	174
Bexar Co.	3,724	1,993	228	204	153	153
Victoria Co.	68	39	9	1	2	2
Other	320	184	34	26	19	19
Region 9/10	1,461	758	154	121	71	71
El Paso Co.	1,009	494	126	89	55	55
Midland Co.	115	62	7	10	6	6
Other	337	202	21	22	10	10
Region 11	1,623	853	156	129	96	96
Cameron/Hidalgo Co.	658	309	82	55	41	41
Nueces Co.	550	312	44	41	28	28
Webb Co.	201	105	15	11	15	15
Other	214	127	15	22	12	12
TX. Dept. of Criminal J.	2,023	725	234	236	387	387
Statewide Total	51,682	28,751	4,201	2,868	2,873	2,973

# Texas AIDS Surveillance Report

## AIDS Cases Reported Quarterly, Year to Date, and Cumulative to Date

Group	Cases Reported October 1-December 31		Cases Reported Year to Date		Cumulative Cases to Date	
	N	( % )	N	( % )	N	( % )
MALES > 12 years	408	(80)	2,332	(81)	45,812	(89)
FEMALES > 12 years	97	(19)	526	(18)	5,501	(11)
TOTAL ADULTS	505	(>99)	2,858	(>99)	51,313	(>99)
TOTAL PEDIATRICS**	3	(<1)	10	(<1)	369	(<1)
TOTAL CASES	508	(100)	2,868	(100)	51,682	(100)

\*\*Cases Reported" comprise newly reported cases entered in the database during the period October 1-December 31.

\*\* Cases in children less than or equal to 12 years of age at time of diagnosis. Excludes 46 patients diagnosed as adults but known to have been infected as children.

## Trends in Cases by Year of Diagnosis and Year of Report

Year	Diagnosed*		Reported**	
	Number	Ave. per mo.	Number	Ave. per mo.
1988 and before	7,486	---	5,636	---
1989	3,221	268	2,587	216
1990	3,707	309	3,162	263
1991	4,086	340	3,024	252
1992	5,108	426	3,229	269
1993	5,390	449	7,498	625
1994	4,912	409	5,456	455
1995	4,700	392	4,539	378
1996	4,661	388	4,824	402
1997	3,811	318	4,645	387
1998	2,748	229	4,214	351
1999 to date	1,852	154	2,868	239
TOTAL CASES	51,682		51,682	

\*Lag time between diagnosis and report to the Texas Department of Health is usually less than 12 months, but can be longer.

\*\*Cases reported in a given month may have been diagnosed that month or at any earlier time.

# Texas AIDS Surveillance Report

## Summary of Cumulative Data Through December 1999

1. Disease Category	Adult/Adolescent *		Pediatric *		Total	
	Cases ( %)	Deaths ( %)	Cases ( %)	Deaths ( %)	Cases ( %)	Deaths ( %)
PCP	16427 ( 32)	12765 ( 78)	138 ( 37)	99 ( 72)	16565 ( 32)	12864 ( 78)
Other Disease w/o PCP	14884 ( 29)	9965 ( 67)	228 ( 62)	115 ( 50)	15112 ( 29)	10080 ( 67)
KS Alone	1515 ( 3)	1101 ( 73)	1 ( 0)	0 ( 0)	1516 ( 3)	1101 ( 73)
No Diseases Listed	18487 ( 36)	4704 ( 25)	2 ( 1)	2 (100)	18489 ( 36)	4706 ( 25)
Total	51313 (100)	28535 ( 56)	369 (100)	216 ( 59)	51682 (100)	28751 ( 56)

2. Age *	Cases ( %)	3. Race/Ethnicity	Adult/Adolescent *	Pediatric *	Total
			Cases ( %)	Cases ( %)	Cases ( %)
Under 5	285 ( 1)	White, Not Hispanic	27583 ( 54)	87 ( 24)	27670 ( 54)
5-12	84 ( 0)	* Afr/Am, Not Hispanic	14054 ( 27)	182 ( 49)	14236 ( 28)
13-19	367 ( 1)	Hispanic	9431 ( 18)	99 ( 27)	9530 ( 18)
20-29	11251 ( 22)	Asian/Pacific Is.	164 ( 0)	1 ( 0)	165 ( 0)
30-39	24231 ( 47)	Am. Indian/Alaskan	68 ( 0)	0 ( 0)	68 ( 0)
40-49	11201 ( 22)	Unknown	13 ( 0)	0 ( 0)	13 ( 0)
Over 49	4263 ( 8)	Total	51313 (100)	369 (100)	51682 (100)
Unknown	0 ( 0)				
Total	51682 (100)				

4. Patient Groups	Adult/Adolescent Transmission Modes**		Total ( %)
	Males ( %)	Females ( %)	
Homosexual or bisexual Men	30901 ( 67)	0 ( 0)	30901 ( 60)
Intravenous (IV) drug User	5095 ( 11)	2047 ( 37)	7142 ( 14)
Homo/Bi IV drug User	4654 ( 10)	0 ( 0)	4654 ( 9)
Coagulation disorder	237 ( 1)	10 ( 0)	247 ( 0)
Heterosexual contact	1732 ( 4)	2368 ( 43)	4100 ( 8)
Transfusion with blood/products	401 ( 1)	225 ( 4)	626 ( 1)
Risk not reported/Other	2792 ( 6)	852 ( 15)	3644 ( 7)
Total	45812 (100)	5502 (100)	51314 (100)

	Pediatric Transmission Modes		Total ( %)
	Males ( %)	Females ( %)	
Coagulation disorder	22 ( 11)	1 ( 1)	23 ( 6)
Parent at risk/has AIDS/HIV	153 ( 78)	149 ( 87)	302 ( 82)
Transfusion with blood/products	20 ( 10)	15 ( 9)	35 ( 10)
Risk not reported/Other	1 ( 1)	7 ( 4)	8 ( 2)
Total	196 (100)	172 (100)	368 (100)

\* Classification at time of AIDS diagnosis.

\*\*46 patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children. They are counted as adults/adolescent cases in tables 1, 2, and 3; and as Adult "Risk/Other" cases in table 4.

# Texas STD Surveillance Report

**Table 1. Chlamydia and Gonorrhea Cases  
January - December 1999**

Residence County	Chlamydia				Gonorrhea			
	1998	1998 Rate	Jan-Dec 1998	Jan-Dec 1999	1998	1998 Rate	Jan-Dec 1998	Jan-Dec 1999
Region 1	3,127	407	3,127	3,220	1,280	167	1,280	1,522
Lubbock Co.	1,181	520	1,181	1,308	671	296	671	801
Potter/Randall Co.	956	451	956	858	403	190	403	414
Other	990	300	990	1,054	206	63	206	307
Region 2	1,542	289	1,542	1,500	597	112	597	619
Taylor Co.	530	428	530	550	205	165	205	285
Wichita Co.	490	384	490	394	235	184	235	184
Other	522	185	522	556	157	56	157	150
Region 3	15,697	300	15,697	15,531	12,014	230	12,014	11,333
Dallas Co.	8,920	418	8,920	9,358	7,444	348	7,444	7,474
Denton Co.	493	128	493	496	208	54	208	147
Tarrant Co.	4,138	282	4,138	3,729	3,331	227	3,331	2,783
Other	2,146	172	2,146	1,948	1,031	83	1,031	929
Region 4/5 N	2,865	222	2,865	3,789	1,624	126	1,624	2,281
Angelina Co.	121	164	121	180	121	164	121	152
Bowie Co.	312	369	312	429	276	326	276	367
Gregg Co.	282	261	282	374	81	75	81	190
Smith Co.	638	383	638	809	381	229	381	574
Other	1,512	176	1,512	1,997	765	89	765	998
Region 6/5 S	15,058	311	15,058	14,460	9,761	202	9,761	8,608
Galveston Co.	683	294	683	681	659	284	659	619
Harris Co.	11,575	360	11,575	10,473	7,237	225	7,237	5,914
Jefferson Co.	966	408	966	1,036	965	407	965	1,048
Montgomery Co.	184	80	184	358	72	31	72	143
Other	1,650	178	1,650	1,912	828	89	828	884
Region 7	7,284	372	7,284	8,764	3,836	196	3,836	4,438
Bell Co.	1,313	627	1,313	1,933	527	252	527	717
Brazos Co.	331	273	331	631	208	171	208	438
McLennan Co.	1,275	663	1,275	1,202	710	369	710	825
Travis Co.	3,017	471	3,017	2,756	1,797	281	1,797	1,542
Other	1,348	169	1,348	2,242	594	75	594	916
Region 8	7,264	355	7,264	7,201	2,287	112	2,287	2,485
Bexar Co.	5,939	442	5,939	5,668	1,873	140	1,873	2,055
Victoria Co.	409	511	409	367	204	255	204	127
Other	916	147	916	1,166	210	34	210	303
Region 9/10	3,238	244	3,238	3,042	728	55	728	451
El Paso Co.	1,698	231	1,698	1,896	256	35	256	155
Midland Co.	453	361	453	247	209	167	209	79
Other	1,087	234	1,087	899	263	57	263	217
Region 11	4,547	276	4,547	5,019	805	49	805	943
Cameron/Hidalgo Co.	2,022	244	2,022	2,563	178	21	178	233
Nueces Co.	1,220	389	1,220	1,133	448	143	448	524
Webb Co.	438	249	438	420	51	29	51	31
Other	867	265	867	903	128	39	128	155
Tx. Dept. of Criminal J.	4		4	0	2		2	0
<b>Statewide Total **</b>	<b>60,626</b>	<b>309</b>	<b>60,626</b>	<b>62,526</b>	<b>32,934</b>	<b>168</b>	<b>32,934</b>	<b>32,680</b>

# Texas STD Surveillance Report

**Table 2. Pelvic Inflammatory Disease and Chancroid  
January – December 1999**

Residence County	Pelvic Inflammatory Disease								Chancroid		
	Chlamydia		Gonorrhea		Other/Unspecified		Total PID		1998	Jan-Dec 1998	Jan-Dec 1999
	Jan-Dec 1998	Jan-Dec 1999	Jan-Dec 1998	Jan-Dec 1999	Jan-Dec 1998	Jan-Dec 1999	Jan-Dec 1998	Jan-Dec 1999			
Region 1	14	7	10	9	3	6	27	22	0	0	0
Lubbock Co.	3	3	2	5	0	4	5	12	0	0	0
Potter/Randall Co.	3	2	3	0	0	1	6	3	0	0	0
Other	8	2	5	4	3	1	16	7	0	0	0
Region 2	59	23	41	14	0	1	100	38	4	4	0
Taylor Co.	22	13	17	6	0	0	39	19	0	0	0
Wichita Co.	18	6	15	5	0	1	33	12	4	4	0
Other	19	4	9	3	0	0	28	7	0	0	0
Region 3	122	145	134	155	562	488	818	788	6	6	8
Dallas Co.	75	86	102	129	473	456	650	671	6	6	4
Denton Co.	2	7	4	4	0	2	6	13	0	0	1
Tarrant Co.	1	0	0	2	67	3	68	5	0	0	2
Other	44	52	28	20	22	27	94	99	0	0	1
Region 4/5 N	8	3	3	3	0	0	11	6	0	0	0
Angelina Co.	1	0	0	0	0	0	1	0	0	0	0
Bowie Co.	0	0	0	0	0	0	0	0	0	0	0
Gregg Co.	0	0	0	1	0	0	0	1	0	0	0
Smith Co.	0	0	1	0	0	0	1	0	0	0	0
Other	7	3	2	2	0	0	9	5	0	0	0
Region 6/5 S	59	91	115	90	267	243	441	424	19	19	7
Galveston Co.	2	45	5	27	0	2	7	74	0	0	0
Harris Co.	46	40	105	58	259	235	410	333	19	19	7
Jefferson Co.	1	1	0	0	1	0	2	1	0	0	0
Montgomery Co.	0	1	0	0	0	2	0	3	0	0	0
Other	10	4	5	5	7	4	22	13	0	0	0
Region 7	68	54	60	63	16	9	144	126	0	0	0
Bell Co.	1	4	0	3	0	0	1	7	0	0	0
Brazos Co.	0	5	0	4	0	0	0	9	0	0	0
McLennan Co.	1	6	0	6	0	0	1	12	0	0	0
Travis Co.	52	28	53	36	3	1	108	65	0	0	0
Other	14	11	7	14	13	8	34	33	0	0	0
Region 8	7	12	5	10	6	13	18	35	0	0	0
Bexar Co.	4	6	1	8	0	11	5	25	0	0	0
Victoria Co.	0	0	1	0	0	0	1	0	0	0	0
Other	3	6	3	2	6	2	12	10	0	0	0
Region 9/10	36	18	23	14	66	6	125	38	4	4	0
El Paso Co.	2	3	2	3	0	1	4	7	4	4	0
Midland Co.	11	8	12	6	11	5	34	19	0	0	0
Other	23	7	9	5	55	0	87	12	0	0	0
Region 11	114	178	8	33	55	10	177	221	0	0	1
Cameron/Hidalgo Co.	34	65	1	7	28	0	63	72	0	0	0
Nueces Co.	45	48	5	13	4	10	54	71	0	0	1
Webb Co.	7	23	1	0	9	0	17	23	0	0	0
Other	28	42	1	13	14	0	43	55	0	0	0
Tx. Dept. of Criminal J.	0	0	0	0	0	0	0	0	0	0	0
<b>Statewide Total **</b>	<b>487</b>	<b>531</b>	<b>399</b>	<b>391</b>	<b>975</b>	<b>776</b>	<b>1861</b>	<b>1698</b>	<b>33</b>	<b>33</b>	<b>16</b>

\* Chlamydia and Gonorrhea PID cases are also included in Table 1: Reported Chlamydia and Gonorrhea Cases



# Texas STD Surveillance Report

**Table 3. Reported Syphilis Cases  
January – December 1999**

Residence County	Congenital			Primary/Secondary				Early Latent			Total Syphilis		
	1998	Jan-Dec 1998	Jan-Dec 1999	1998	1998 Rate	Jan-Dec 1998	Jan-Dec 1999	1998	Jan-Dec 1998	Jan-Dec 1999	1998	Jan-Dec 1998	Jan-Dec 1999
Region 1	0	0	0	5	1	5	2	16	16	7	52	52	32
Lubbock Co.	0	0	0	2	1	2	1	2	2	2	12	12	8
Potter/Randall Co.	0	0	0	0	0	0	1	5	5	1	14	14	4
Other	0	0	0	3	1	3	0	9	9	4	26	26	20
Region 2	0	0	1	5	1	5	9	0	0	11	25	25	53
Taylor Co.	0	0	0	0	0	0	0	0	0	0	9	9	2
Wichita Co.	0	0	1	4	3	4	7	0	0	8	10	10	29
Other	0	0	0	1	0	1	2	0	0	3	8	8	22
Region 3	26	26	7	153	3	153	178	561	561	457	990	990	888
Dallas Co.	23	23	4	124	6	124	152	405	405	380	752	752	691
Denton Co.	0	0	0	1	0	1	1	3	3	1	8	8	3
Tarrant Co.	3	3	3	22	2	22	20	119	119	64	171	171	171
Other	0	0	0	6	0	6	5	14	14	12	58	58	22
Region 4/5 N	4	4	4	50	4	50	54	167	167	135	294	294	256
Angelina Co.	0	0	1	6	8	6	7	26	26	23	33	33	35
Bowie Co.	0	0	0	8	9	8	2	11	11	6	21	21	10
Gregg Co.	0	0	0	16	15	16	2	12	12	6	32	32	10
Smith Co.	0	0	1	5	3	5	15	24	24	22	30	30	45
Other	4	4	2	15	2	15	28	94	94	78	178	178	168
Region 6/5 S	59	59	50	133	3	133	132	481	481	408	1,638	1,638	1,451
Galveston Co.	0	0	1	5	2	5	1	22	22	42	29	29	47
Harris Co.	51	51	47	96	3	96	70	357	357	240	1,400	1,400	1,102
Jefferson Co.	3	3	0	15	6	15	16	41	41	31	85	85	87
Montgomery Co.	0	0	1	1	0	1	2	7	7	10	10	10	23
Other	5	5	1	16	2	16	43	54	54	85	114	114	197
Region 7	0	0	1	42	2	42	32	73	73	78	204	204	310
Beil Co.	0	0	0	11	5	11	4	7	7	3	32	32	23
Brazos Co.	0	0	0	3	2	3	1	20	20	10	29	29	17
McLennan Co.	0	0	0	4	2	4	3	6	6	2	25	25	22
Travis Co.	0	0	0	15	2	15	18	18	18	23	57	57	51
Other	0	0	1	9	1	9	6	22	22	40	61	61	197
Region 8	5	5	5	33	2	33	39	72	72	78	280	280	254
Bexar Co.	4	4	4	26	2	26	31	61	61	71	242	242	227
Victoria Co.	0	0	0	2	2	2	4	3	3	2	10	10	8
Other	1	1	1	5	1	5	4	8	8	5	28	28	19
Region 9/10	1	1	1	5	0	5	10	20	20	13	177	177	182
El Paso Co.	0	0	1	2	0	2	9	14	14	9	84	84	79
Midland Co.	0	0	0	1	1	1	0	3	3	2	5	5	16
Other	1	1	0	2	0	2	1	3	3	2	88	88	87
Region 11	4	4	23	3	0	3	3	66	66	53	303	303	221
Cameron/Hidalgo Co.	2	2	22	1	0	1	2	33	33	36	182	182	129
Nueces Co.	1	1	0	0	0	0	1	13	13	9	26	26	20
Webb Co.	1	1	0	1	1	1	0	10	10	5	35	35	19
Other	0	0	1	1	0	1	0	10	10	3	80	80	57
Tx. Dept. of Criminal J.	0	0	0	1		1	0	4	4	0	12	12	0
Statewide Total **	99	99	92	430	2	430	459	1,460	1,460	1,240	3,975	3,975	3,547

\* Rates are per 100,000 population

\*\* Total Syphilis includes all reported cases of syphilis, regardless of stage



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